FINE

STATE COMPLIANCE WITH FEDERAL MEDICAID REQUIREMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

JUNE 7, 1976

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

74-904 O WASHINGTON : 1976

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MONDAY, JUNE 7, 1976

U.S. SENATE,
SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON FINANCE,
Washington, D.C.

The subcommittee met at 9:30 a.m., pursuant to notice, in room 2228, Dirksen Senate Office Building, Senator Herman E. Talmadge (chairman of the subcommittee) presiding.

Present: Senators Long, Talmadge, and Dole.

Senator TALMADGE. The subcommittee will be in order.

This morning the Subcommittee on Health will consider a significant aspect of Federal-State relations; that is: Whether present procedures and sanctions are adequate and equitable when questions of State compliance with the Federal requirements are raised.

A specific problem relating to hospital reimbursement has arisen in Illinois. We will hear about that situation this morning from distinguished witnesses.

States other than Illinois have been and will be confronted with changes and charges of noncompliance with Federal standards. We want, therefore, to also hear testimony on the broader issue with a view hopefully toward development of agreement on fair and timely procedures and sanctions.

In December of 1975 Congress approved an amendment, section 111 of Public Law 94–182, which required States to waive their constitutional right of immunity to sue. This provision is intended to permit hospitals to sue where they believe the State is not paying them in accordance with Federal requirements. If a State does not waive that right it suffers substantial reductions in Federal medicaid funding.

The House of Representatives has just passed legislation to repeal that amendment. The bill H.R. 12961 is now before the Finance Committee. There are responsible Senators who endorse repeal of section 111 but only if it provides more workable and timely procedures than we have at the present for resolving the compliance issues. In that regard I hope that this hearing proves productive and constructive.

Our first witness this morning represents the Department of Health, Education, and Welfare. Mr. Kurzman, will you please come forward—I see you already are at the witness desk—and introduce your associates?

STATEMENTS OF STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; WILLIAM HOWARD TAFT IV, GENERAL COUNSEL; KEITH WEIKEL, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; AND WILLIAM A. MORRILL, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

Mr. KURZMAN. Thank you, Mr. Chairman; I will be happy to do that. On my right is William Morrill, Assistant Secretary for Planning and Evaluation; and on my left is Dr. Keith Weikel, Administrator of the Medical Services Administration in the Social Rehabilitation Service of the Department of HEW.

Mr. Chairman and members of the subcommittee, I am pleased to be here today with my colleagues to discuss with you several issues connected with the administration of the medicaid program as you have outlined it in your own opening statement, Mr. Chairman, and our proposals for dealing with them.

Before addressing the specific issues, I think it would be worthwhile to look briefly at the medicaid program in general and at the area of costs under medicaid in particular. Medicaid, of course, is a Federal-State program whose objective is providing payment for medical services to certain low-income groups. The Federal Government provides matching payments at a rate of 50 to 78 percent for covered medical services provided to eligible recipients.

The principal responsibility for administering the program is with the States. Within broad Federal limits established by statute and regulations, States have discretion in establishing eligibility, the scope or amount of benefits, the methods of administration and reimbursement levels.

In the current fiscal year, we estimate that services will be provided under the medicaid program to at least 23 million Americans at a cost of $15 billion. Expenditures in this program have been increasing at about $2 billion a year since 1970 and all indications are that expenditures will continue to increase dramatically.

These large increases in expenditures have become more critical as the fiscal pressure facing States increases. This has resulted, in some States, in the reduction or elimination of optional services, reduction in the duration and amount of mandated services and reduction in reimbursement levels or slowing of the payment rate.

However, since about 70 percent of medicaid funds are spent for institutional care, divided about evenly between inpatient hospital services and nursing home services—which, as of July 1, will be reimbursed on a reasonable cost-related basis—there is little the State can do to control a large segment of its program costs.

To deal with this situation, some States have announced or implemented various changes in their reimbursement method in an attempt to control reasonable costs.

Section 111 of Public Law 94–182, which Congress passed in December 1975, required State to give providers of inpatient hospital services access to Federal court to contest the reasonableness of a State's reimbursement system.

Section 111 amends title XIX of the Social Security Act to require the State plan to include consent by the State to suit in Federal court

by or on behalf of any provider of inpatient hospital services with respect to the payment of reasonable costs of inpatient hospital services and a waiver of immunity from such a suit under the 11th amendment to the Constitution.

The section also provides that a penalty of 10 percent of the total medicaid funds otherwise payable to a State shall be applied in any quarter in which the Secretary finds that the State plan does not comply with these requirements. As of June 3, 18 States had failed or refused to amend their plan. As you know, the Department supported the legislation to repeal section 111, which the House of Representatives passed last month.

To more fully understand the situation section 111 was trying to address, it would be beneficial to review current reimbursement practices under the medicaid program. Section 1902(a)(13)(D) requires that providers of inpatient hospital services be reimbursed on the basis of reasonable cost. States are required to follow the same principles of reimbursement employed by medicare unless a State obtains approval from the Secretary for the use of an alternative method of cost reimbursement. At present only four States are using an alternative method.

Under the title XVIII reimbursement principles, a hospital is paid an interim rate during the accounting year with a retroactive adjustment at the end of the year. The law we are discussing, Public Law 94–182, was passed to deal with problems such as have arisen in the State of Illinois. The State reimburses hospitals under the title XVIII principles.

However, Illinois recently froze its interim payment rate to hospitals while claiming that in doing so it was not employing an alternative reimbursement system, which would need Federal approval and which also would have to provide an appeals system for hospitals.

Thus, because of procedural intricacies in the Illinois courts, the providers of inpatient hospital services in Illinois were left without adequate recourse. Although the hospitals will receive full costs at the end of the accounting year, providers claim that the temporary savings to the States cause hospitals critical cash flow problems for which, before the passage of section 111, there was no adequate remedy.

At present, providers have several possible recourses which, if applicable, would provide mechanisms for due process:

One: State court relief is available in most States. This relief would be adequate unless, for example, State court deemed the Federal Government to be a necessary party to any action or if other procedural barriers prevented providers from full recovery. We are at this point uncertain of the extent of these barriers.

Two: The Department can institute compliance hearings to determine if the action taken by the State was out of compliance with medicaid regulations. However, this would not provide retroactive relief to providers who may have been injured as a result of the State's being out of compliance with the State plan. I will discuss the compliance process more fully later.

Three: Access to Federal courts is available for injunctive relief against State officials. Under the 11th amendment, however, a State may not be sued for damages in Federal court without its consent.

Four: Since the passage of Public Law 94–182, States are required to consent to be sued in Federal court. However, we oppose section 111 in its present form, as I indicated earlier, because it would impose substantial penalties on noncomplying States without providing those States sufficient time in which to comply. We have not had sufficient time to consult with the Department of Justice. HEW is not, however, opposed to legislation which would subject the States to the jurisdiction of the Federal courts. For example, we would not object to a bill which would deem continued State participation in the medicaid program to be a waiver of its immunity to suits by providers in Federal court. Such legislation would not place States in jeopardy of losing any medicaid funds because of State incapacity to act within a specific period.

Under present law the Department's principal enforcement mechanism is compliance hearings. The area of compliance dates back to the establishment of the medicaid program in 1965. Section 1904 of the Social Security Act requires the Secretary to give reasonable notice and opportunity for hearings to a State advising them that either they are out of compliance with a provision of the medicaid plan or that the plan no longer complies with requirements for the State plans.

The process can be a lengthy and complicated one. It basically provides for:

One: Identification by the regional office of an issue whereby a State may be out of compliance with its plan.

Two: Determination by the regional office of required action. If the State corrects the deficiency, no further involvement of the regional office is necessary.

Three: Where the State refuses to take a recommended action or if more time is required to correct the deficiency, a process of negotiation begins. The regional office has some leeway in this process, which is an informal one but which can include conferences among the regional director, HEW, regional commissioner/SRS and the State Governor.

Four: The SRS administrator may confer with State officials to attempt to resolve the issues if the negotiations fail or there are other indications that the State is unwilling to take corrective action.

Five: The regional commissioner can recommend to the administrator that a formal hearing take place.

Six: If the administrator agrees that a hearing is necessary a hearing official will hear the case.

Seven: The State is given an opportunity to present evidence, as is the administration. Following an unfavorable decision, the State may appeal to the U.S. Court of Appeals and, if the State loses at that point, to the U.S. Supreme Court.

Because of the opportunity for ultimate appeal to the courts, all compliance cases must be prepared, from the beginning, with the same thoroughness as any litigation. Obviously this is a time-consuming process. As a consequence, the Department must be convinced the case is sufficiently well grounded to withstand challenge in the courts. Thus complaints by providers or others are not necessarily grounds for compliance action.

Nonetheless, Mr. Chairman, we are finding that currently there are approximately 500 such actions per year. To date there have been two

compliance hearings regarding medicaid issues. A third hearing scheduled for a State was canceled after the State came into compliance.

The first hearing, in 1970, involved the State of Connecticut. The hearing examiner agreed that the State's medicaid reimbursement methods did not meet regulatory requirements and found that the State was out of compliance. The State appealed the decision to the Supreme Court and lost. The State came into compliance in November 1971.

The second hearing, involving the State of Missouri, took place in 1971. The hearing examiner agreed that the State was out of compliance with regulations concerning home health services. The State resolved the issue by coming into compliance in July 1971.

Section 1904 of the act requires the Secretary to withhold payment to a State until he is satisfied that there are no longer areas in which the State is out of compliance. A failure to comply requires the cutoff of further payments to the State. This very broad withholding requirement was modified in 1968 to allow the Secretary to withhold lesser amounts by permitting payments for categories of the State plan not out of compliance.

An example might be helpful. In fiscal year 1975 the State of Illinois' total medicaid expenditures were close to $714 million. If the State was out of compliance in, for example, inpatient hospital care, the Secretary would be required to withhold all funds within that category, which amount to 36 percent of the total, or $255 million. If Ohio was similarly out of compliance with the in-hospital care regulations, we would be required to withhold 33 percent of its Federal funding, over $122 million.

We feel that withholding a substantial amount of money from the States hurts both recipients and providers. We do not believe that the end result of failing to comply with myriad program requirements should invariably be the crippling of the very program the requirements were designed to serve. However, the Department is aware of the obligation to uphold the law as it now is and has therefore introduced legislation providing for a more realistic assessment of penalties.

Let me now turn to those legislative proposals, both of which are pending before this committee.

The Department is keenly aware of the need for a more rational approach to the delivery of health care services under medicaid. One of Secretary Mathews' first concerns when he came to the Department was the issue of penalties and compliance. As a result he conducted a study of the potential impact of penalties on States, providers and recipients.

One result of that study is the proposed legislation we transmitted to the Congress on May 21, 1976, which would revise the payment reduction required in cases of inadequate utilization controls. Basically the legislation modifies section 1903(g), which requires the Secretary to withhold funds from States which do not have an effective program of utilization control.

The bill is intented as an interim measure pending enactment of the administration's Financial Assistance for Health Care Act. The interim bill will provide more effective incentives for States to develop programs for controlling the utilization of services provided by hospitals and long-term care facilities.

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The bill would also reduce the amount of the statutory reduction from one-third of the Federal medical assistance percentage for long stay patients in all institutions in the State to 5 percent of the Federal medical assistance percentage for all patients in whichever class of medical institution there has been a finding of noncompliance.

Finally, the bill would clarify that the imposition of payment reductions be made on a quarterly basis rather than annually. This change would provide a greater short-term incentive for a State to bring its utilization control program into conformity with the statute and is clearly, in our view, more equitable.

As further incentive to the States, the Secretary would have authority to postpone the imposition of a payment reduction for any State which has developed a satisfactory plan for remedying the deficiencies in its utilization control program. A State would have no more than 6 months to conform its program to the statute.

We believe this would encourage a State to act quickly to correct any deficiencies in its program and avoid imposition of the penalty.

I would also like to mention the bloc grant proposal. As I mentioned earlier, the administration has also proposed to the Congress the Financial Assistance for Health Care Act, which was transmitted on February 25, 1976. Our block grant bill would improve delivery of health services to the poor by consolidating 16 Federal health programs, including medicaid, into one $10 billion block grant to the States.

The proposal included a requirement for development by the States of a State health care plan. Public participation in the development of the plan is required to insure that increased State responsibility is coupled with expanding public accounting of State health policies.

Enactment of this proposal would in the long term, we believe, solve the problems addressed by section 111 and our previously described draft bill.

Mr. Chairman, I will be pleased to answer questions and provide whatever further information we can. May I also add that William Taft, the Department's general counsel, has also joined us at the table.

Senator TALMADGE. Thank you very much, Mr. Secretary. When was the issue of Illinois' compliance with section 232 first raised by the Department?

Mr. KURZMAN. I will let Dr. Weikel answer that.

Dr. WEIKEL. The first indication we had of any change in the reimbursement method in the inpatient sector was a letter which was submitted to our regional office on October 6 by the State of Illinois.

Senator TALMADGE. October 6, when?

Dr. WEIKEL. 1975.

Senator TALMADGE. That was 1975?

Dr. WEIKEL. Yes, sir.

Senator TALMADGE. What specific steps has the Department taken from the time this issue was raised and when were they taken?

Dr. WEIKEL. The October 6 letter which was sent to the commissioner of our Chicago regional office described what the State was proposing to do and indicated that there would be no interim rate increases. They were asking in that letter for an alternative reimbursement system.

After analyzing the information provided in that letter it was the determination of the regional commissioner that he had inadequate

information on which to approve an alternate reimbursement system. On November 7, Commissioner Downing wrote the State and told them that he needed more information.

At that time he also expressed concern about the freeze which they were proposing to implement in the interim payments to hospitals.

The State responded on December 17 to Commissioner Downing and indicated that they promised to develop standards and more detail. They also objected at that point to Commissioner Downing's reference in his letter to the concept of a freeze, indicating that they really weren't freezing payments, that payments would be made after the review mechanism or the review board they were establishing was operational.

On January 8 we again wrote the State and informed them that the information we had was inadequate to make a decision. It also put them on notice in that letter that we expected them to abide by the title XVIII reimbursement principles.

There were a number of other pieces of correspondence between State representatives and the Department in January. Essentially, on January 19 a letter from the Governor to the President was sent, objecting to the actions of the Department and indicating that they felt we were not making an accurate interpretation of the regulations, and so forth. There was also a letter from Mr. Trainor of the Illinois Department of Public Assistance to Secretary Mathews, complaining about our regional commissioner's position.

At that point the State seemed to take the position that they are really not asking for an alternative reimbursement system, that they are simply altering or modifying slightly the title XVIII reimbursement principles.

On February 19 we drafted correspondence for the State. However, about that time—I think it was exactly February 19—the State filed suit against the Department.

Senator TALMADGE. I would suggest that you supply the chronology for the record and then I will proceed to the next question.

[The chronology to be supplied follows:]

ILLINOIS CHRONOLOGY

July 7, 1975: The projected 1976 Medicaid budget for Illinois was reduced by six percent by an amendatory veto on the Governor. This amounted to a reduction of about $50 million from the original request of $827 million.

July 31, 1975: The Illinois Department of Public Aid issued a news release outlining its plan to affect the reduction. The plan included:

Nursing home rates would be frozen at their August 1, 1975 level;

There would be a new requirement that physicians document a patient's need for over-the-counter drugs;

Pharmacies would be paid actual wholesale cost plus a $1.75 flat rate to cover additional costs, as of August 1, 1975. This would amount to less than the previous policy of paying a 30 percent mark-up on cost plus a $1.35 professional fee; and

The Department of Public Aid was studying various alternatives that could decrease the amount of money paid to hospitals.

October 6, 1975: James Trainor, Director of the Illinois Department of Public Aid, requested Clyde Downing, SRS Regional Commissioner in Chicago, to approve an alternative plan for the reimbursement of inpatient hospital services, which it was putting into effect. The plan included the following major provisions:

It established a Review Board to evaluate the reasonableness and necessity of costs incurred. Costs that the Board found excessive would not be recognized; and

No interim rate increase would be granted after October 6, 1975, for cost periods ending June 1, 1975 or later, until after the Board completed its review.

October 28, 1975: The Illinois Hospital Association filed suit against Illinois to halt the interim payment freeze because it does not pay reasonable costs.

October 30, 1975: The Court denied a motion for a preliminary injunction to halt the freeze.

November 7, 1975: Commissioner Downing wrote Director Trainor that he could not approve the alternative plan as submitted. The Commissioner listed seven aspects of the plan that would need clarification and/or revision prior to any approval. Among the points raised were:

More specificity was needed in the standards or criteria that would be used by the Board to determine the reasonableness of allowable costs;

The scope of review allowed on provider appeals seemed unduly narrow; and

The section on interim rates was confusing, inconsistent, and the imposition of a "freeze" on interim rates raises a question of comliance with 20 CFR 405.454.

November 10, 1975: Director Trainor announced the appointment of the three member Review Board.

December 17, 1975. Director Trainor provided a preliminary response to Commissioner Downing's objections and indicated that he would follow-up with additional information. He indicated that the newly appointed Review Board would establish standards of review.

January 8, 1976: Commissioner Downing responded to Director Trainor's letter of December 17, 1975, indicating that it contained insufficient information upon which to approve the alternative plan. He reminded the State that it must reimburse providers according to its approved State Plan.

January 15, 1975: Commissioner Downing met with representatives of the Illinois Department of Public Aid to discuss the proposed alternative reimbursement system. The result of the meeting was that Commissioner Downing reaffirmed his decision made in his letter to Director Trainor of January 8, 1976.

January 19, 1976: Governor Walker wrote to President Ford requesting him to give his personal attention to the matter, but did not resubmit the plan for approval or offer any modifications.

February 6, 1976: Director Trainor wrote Secretary Mathews requesting that the reimbursement proposal not be classified as an alternative plan for reimbursement or as an amendment to Illinois' State Plan, either of which would require prior approval by the Regional Commissioner. Alternatively, if the proposal does require approval, it was requested that the Secretary approve it.

February 10, 1976: Illinois filed suit against HEW to force HEW to allow the State to implement its reimbursement proposal. The State argued that the proposal did not constitute a change in the State Plan and consequently did not require approval. The suit was dropped by the State in May 1976.

March 4, 1976: Senator Percy and Senator Stevenson jointly requested Secretary Mathews to promptly take appropriate action to assure the State agency's compliance with existing laws and regulations.

March 22, 1976: The Secretary responded to Director Trainor's letter of February 6, 1976, stating that authority was delegated to Commissioner Downing to decide whether the State's proposal required approval as a State Plan Amendment and, if so, to decide on approval or disapproval.

June 9, 1976: Commissioner Downing cited Illinois as being out of compliance with the regulation requiring the reimbursement of the reasonable cost of inpatient hospital services, for the quarter ending March 31, 1976.

Senator TALMADGE. Why has it taken you so long to resolve this issue?

Mr. MORRILL. Essentially the process from February until approximately the end of April in terms of the issue of whether they are in compliance was in the court system because we had a suit against us, and, therefore, we were tied up in the legal proceedings.

Senator TALMADGE. Was the suit filed by the State of Illinois?

Mr. MORRILL. Yes, it was. The suit has now been dismissed and we are now proceeding to cite the State of Illinois for compliance action.

Senator TALMADGE. If the State proposed to limit increases in hospital reimbursement in 1977 at not more than 7 percent of what was paid in 1976, would the 7-percent limitation be considered reasonable by HEW?

Mr. KURZMAN. I don't know what the answer to that would be. As you know, we have made a proposal to the Congress that the Congress impose statutory ceilings on such increases under medicare; and I would say, by implication, that we would be asking the Congress—or we would tend to favor, at least—the asking of Congress to participate with us in the setting of such a ceiling.

Senator TALMADGE. As I understand, the limitation of 7 percent on medicare and medicaid has been proposed. It that right?

Dr. WEIKEL. The legislation affects medicare but, by implication, it would impact medicaid as well.

Senator TALMADGE. Do you know whether that would be reasonable?

Dr. WEIKEL. We think is was reasonable, and that is why it was proposed.

Mr. KURZMAN. But I think your question was whether we would take unilateral action to impose such a ceiling, and I do not think that we would do so.

Senator TALMADGE. If the State proposed or put a 7-percent limit on, would that be reasonable in your judgment?

Mr. KURZMAN. The implication of what we said before was that we would invite the Congress first to participate in the setting of that ceiling, as we have by proposing the bill.

Senator TALMADGE. Does the Department believe and has it found the present procedures and sanctions adequate to deal fairly and expeditiously with compliance issues between the Federal and State governments?

Mr. KURZMAN. That calls for a complex answer, Mr. Chairman, and I would like my colleagues to amplify. As we have said in our statement, the administration is not happy with the narrow question of penalties and enforcement that we now have and therefore has proposed, particularly in the area of 1903(g), utilization of some controls to modify them so that they do impact severely on the deliverer of needed health services.

In the longer term, we believe the program is unduly restrictive and oppressive from the Federal point of view and that, in fact, the States should have a great deal more latitude to design their own programs than they now do.

We estimate that title XIX has anywhere from 85 to 100 explicit, broad statutory requirements which, by implication, we are required to flesh out with hundreds of regulatory requirements. These, in turn, impose an enormous compliance burden on both us and the States. This is why the administration has proposed the bloc grant, which would simplify those requirements enormously and reduce the statutory requirements to something in the order of a dozen.

Also, forcing the development of State plans into a public kind of accountability, a processing which the public could participate in, it would also eliminate the necessity for the issuance of us of these hundreds of regulatory requirements.

I guess the bottom line is that we are not happy with the complex of both Federal requirements on the States and penalty provisions

which now exist, both in the narrow sense of section 111 and in the broader sense of the entire medicaid program.

Senator TALMADGE. Your recommendation for improvement of this program is limited to a bloc grant program?

Mr. KURZMAN. No, Mr. Chairman; that would be our clearly preferred long-term solution. In the short term we are really making two proposals to you. I should amend what I said earlier. One, of course, is the 1903(g) change which I have described in the statement and have just alluded to. The other short-term change is to repeal section 111, which we find again unnecessarily harsh to achieve the purpose.

As I indicated, HEW would not object if, in lieu of section 111, the Congress were to enact a provision deeming the States to have waived immunity from suit in the Federal courts by their participation in the medicaid program.

Senator TALMADGE. Does the bloc grant program mandate how the States should pay the hospitals or does it leave it open for the States to make their determination?

Mr. KURZMAN. Let me turn to Mr. Morrill. It does leave it open.

Mr. MORRILL. It does leave it within a broad framework so that the States will have a system, but it is of their devising as to how that reimbursement system will be done.

Senator TALMADGE. In other words, the States will make the decision?

Mr. MORRILL. The States make the decision subject to the open planning process that is required as part of the legislation.

Senator TALMADGE. Do you have any questions, Senator Dole?

Senator DOLE. No.

Senator TALMADGE. Thank you very much. We appreciate your cooperation.

[The prepared statement of Mr. Kurzman follows:]

STATEMENT OF STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. Chairman, members of the subcommittee, I am pleased to be here today to discuss with you several issues connected with the administration of the medicaid program and our proposals for dealing with them. Before addressing specific issues, I think it would be worthwhile to briefly look at the medicaid program in general and at the area of costs under medicaid in particular.

THE MEDICAID PROGRAM

Medicaid is a Federal/State program whose objective is providing payment for medical services to certain low income groups. The Federal Government provides matching payments at a rate of 50 to 78 percent for covered medical services provided to eligible recipients. The principal responsibility for administering the program is with the States. Within broad Federal limits established by statute and regulations, States have discretion in establishing eligibility, the scope or amount of benefits, the methods of administration and reimbursement levels.

In the current fiscal year, we estimate that services will be provided under the medicaid program to at least 23 million Americans at a cost of $15 billion. Expenditures in this program have been increasing at about $2 billion a year since 1970, and all indications are that expenditures will continue to increase dramatically.

These large increases in expenditures have become more critical as the fiscal pressure facing States increases. This has resulted in some States, in the reduction or elimination of optional services, reduction in the duration and amount of mandated services and reduction in reimbursement levels or slowing of the payment rate.

However, since about 70 percent of medicaid funds are spent for institutional care divided about evenly between inpatient hospital services and nursing home services, which, as of July 1, will be reimbursed on a reasonable cost related basis, there is little the State can do to control a large segment of its program costs. To deal with this situation, some States have announced or implemented various changes in their reimbursement method, in an attempt to control reasonable costs.

SECTION 111 OF PUBLIC LAW 94–182 "CONSENT BY STATES TO CERTAIN SUITS"

In light of the changes in reimbursement systems, Congress passed, in December 1975, section 111 of Public Law 94–182 which required States to give providers of inpatient hospital services access to Federal court to contest the reasonableness of a State's reimbursement system.

Section 111 amends title XIX of the Social Security Act to require the State plan to include consent by the State to suit in Federal court by or on behalf of any provider of inpatient hospital services with respect to the payment of reasonable costs of inpatient hospital services, and a waiver of immunity from such a suit under the 11th amendment to the Constitution. The section also provides that a penalty of 10 percent of the total medicaid funds otherwise payable to a State shall be applied in any quarter in which the Secretary finds that the State plan does not comply with these requirements. As of June 3, 18 States had failed or refused to amend their plan. As you know, the Department supported the legislation to repeal section 111 which the House of Representatives passed last month.

CURRENT REIMBURSEMENT PRACTICES AND SECTION 111

To more fully understand the situation section 111 was trying to address, it would be beneficial to review current reimbursement practices under the medicaid program. Section 1902(a)(13)(D) requires that providers of inpatient hospital services be reimbursed on the basis of reasonable cost. States are required to follow the same principles of reimbursement employed by medicare, unless a State obtains approval from the Secretary for the use of an alternative method of cost reimbursement. At present, only four States are using an alternative method.

Under the title XVIII reimbursement principles, a hospital is paid an interim rate during the accounting year, with a retroactive adjustment at the end of the year. The law we are discussing, Public Law 94–182, was passed to deal with problems such as have arisen in the State of Illinois. The State reimburses hospitals under the title XVIII principles. However, Illinois recently froze its interim payment rate to hospitals, while claiming that, in doing so, it was *not* employing an alternative reimbursement system, which would need Federal approval and which also would have to provide an appeals systems for hospitals. Thus, because of procedural intricacies in the Illinois courts, the providers of inpatient hospital services in Illinois were left without adequate recourse. Although the hospitals will receive full costs at the end of the accounting year, providers claim that the temporary savings to the States cause hospitals critical cash flow problems for which, before the passage of section 111, there was no adequate remedy.

REMEDIES NOW AVAILABLE TO PROVIDERS

Providers have several possible recourses, which, if applicable, would provide mechanisms for due process:

1. State court relief is available in most States. This relief would be adequate unless, for example, State court deemed the Federal Government to be a necessary party to any action, or if other procedural barriers prevented providers from full recovery. We are uncertain of the extent of these barriers.

2. The Department can institute compliance hearings to determine if the action taken by the State was out of compliance with medicaid regulations. However, this would not provide retroactive relief to providers who may have been injured as a result of the State being out of compliance with their State plan. I will discuss the compliance process more fully later.

3. Access to Federal courts is available for injunctive relief against State officials. Under the 11th amendment, however, a State may not be sued for damages in Federal court without its consent.

4. Since the passage of Public Law 94–182, States are required to consent to be sued in Federal court. However, we oppose section 111, because it would impose

substantial penalties on noncomplying States without providing those States sufficient time in which to comply. We have not had sufficient time to consult with the Department of Justice. HEW is not, however, opposed to legislation which would subject the States to the jurisdiction of the Federal courts. For example, we would not object to a statute that deems continued State participation in the medicaid program to be a waiver of its immunity to suits by providers in Federal court. Such legislation would not place States in jeopardy of losing any medicaid funds because of State incapacity to act within a given period.

COMPLIANCE

Under present law, the Department's principal enforcement mechanism is compliance hearings. The area of compliance dates back to the establishment of the medicaid program in 1965. Section 1904 of the Social Security Act requires the Secretary to give reasonable notice and opportunity for hearings to a State, advising them that either they are out of compliance with a provision of the medicaid plan or that the plan no longer complies with requirements for the State plans.

The process can be a lengthy and complicated one. It basically provides for:

1. Identification by the regional office of an issue whereby a State may be out of compliance with its plan.

2. Determination by the regional office of required action. If the State corrects the deficiency, no further involvement of the regional office is necessary.

3. Where the State refuses to take a recommended action, or if more time is required to correct the deficiency, a process of negotiation begins. The regional office has some leeway in this process, which is an informal one, but which can include conferences among the regional director, HEW, Regional Commissioner/srs, and the State Governor.

4. The SRS administrator may confer with State officials to attempt to resolve the issues if the negotiations fail or there are other indications that the State is unwilling to take corrective action.

5. The Regional Commissioner can recommend to the administrator that a formal hearing take place.

6. If the administrator agrees that a hearing is necessary, a hearing official will hear the case.

7. The State is given an opportunity to present evidence as is the Administration. Following an unfavorable decision the State may appeal to the U.S. Court of Appeals and if the State loses, to the Supreme Court.

Because of the opportunity for ultimate appeal to the courts, all compliance cases must be prepared, from the beginning, with the same thoroughness as any litigation. Obviously, this is a time-consuming process. As a consequence, the Department must be convinced the case is sufficiently well grounded to withstand challenge in the courts. Thus, complaints by providers, or others, are not necessarily grounds for compliance action.

To date, there have been two compliance hearings regarding medicaid issues. A third hearing scheduled for a State was canceled after the State came into compliance. The first hearing, in 1970, involved the State of Connecticut. The hearing examiner agreed that the State's medicaid reimbursement methods did not meet regulatory requirements and found that the State was out of compliance. The State appealed the decision to the Supreme Court and lost. The State came into compliance in November 1971. The second hearing, involving the State of Missouri, took place in 1971. The hearing examiner agreed that the State was out of compliance with regulations concerned with provisions of home health services. The State resolved the issue by coming into compliance in July 1971.

Section 1904 of the act requires the Secretary to withhold payment to a State until he is satisfied that there are no longer areas in which the State is out of compliance. A failure to comply requires the cutoff of further payments to the State. This very broad withholding requirement was modified in 1968 to allow the Secretary to withhold lesser amounts by permitting payments for categories of the State plan not out of compliance. An example might be helpful. In fiscal year 1975, the State of Illinois' total medicaid expenditures were close to $714 million. If the State was out of compliance in, for example, in patient hospital care, the Secretary would be required to withhold all funds within that category, which amount to 36 percent of the total or $225 million. If Ohio was similarly out of compliance with the in-hospital care regulations, we would be required to withhold 33 percent of its Federal funding—over $122 million.

We feel that withholding a substantial amount of money from the States ends in hurting both recipients and providers. We do not believe that the end result of failing to comply with myriad program requirements should invariably be the crippling of the very program that requirements were designed to serve. However, the Department is aware of the obligation to uphold the law, and has therefore introduced legislation providing for a more realistic assessment of penalties.

PENALTIES AND INCENTIVES

The Department is keenly aware of the need for a more rational approach to delivery of health care services under medicaid. One of Secretary Mathews' first concerns when he came to the Department was the issue of penalties and compliance. As a result, he conducted a study of the potential impact of penalties on States, providers and recipients. One result of that study is the proposed legislation we have transmitted to the Congress which would revise the payment reduction required in cases of inadequate utilization controls. Basically, the legislation modifies section 1903(g), which requires the Secretary to withhold funds from States who do not have an effective program of utilization control.

The bill is intended as an interim measure pending enactment of the administration's Financial Assistance for Health Care Act. It will provide more effective incentives for States to develop programs for controlling the utilization of services provided by hospitals and long-term care facilities. The bill would also reduce the amount of the statutory reduction from one-third of the Federal medical assistance percentage for long-stay patients in all institutions in the State to 5 percent of the Federal medical assistance percentage for all patients in which every class of medical institution there has been a finding of noncompliance.

Finally, the bill would clarify that the imposition of payment reductions be made on a quarterly basis, rather than annually. This change would provide a greater short term incentive for a state to bring its utilization control program into conformity with the statute, and is clearly more equitable. As a further incentive to the States, the Secretary would have authority to postpone the imposition of a payment reduction for any State which has developed a satisfactory plan for remedying the deficiencies in its utilization control program. A State would have no more than 6 months to conform its program to the statute. We believe this would encourage a State to act quickly to correct any deficiencies in its program, since, if it does so in the time provided, it will avoid the imposition of a penalty.

THE BLOC GRANT

As I mentioned earlier, the administration has also proposed to the Congress the "Financial Assistance for Health Care Act" which would improve delivery of health services to the poor by consolidating 16 Federal health programs, including medicaid, into one $10 billion bloc grant to the States. The proposal included a requirement for the development by States of a State health care plan. Public participation in the development of the plan is required to insure that increased State responsibility is coupled with expanding public accounting of State health policies. Enactment of this proposal would, in the long term, solve the problems to which section 111 and our previously described draft bill are addressed.

Mr. Chairman, I will be pleased to answer questions and provide whatever further information I can.

Senator TALMADGE. The next witness is the Honorable Marvin Mandel, Governor of the State of Maryland, representing the National Governors' Conference. Governor, we are honored indeed to have you with us this morning.

STATEMENT OF HON. MARVIN MANDEL, GOVERNOR OF THE STATE OF MARYLAND, REPRESENTING THE NATIONAL GOVERNORS' CONFERENCE, ACCOMPANIED BY JACK KENT, SECRETARY OF THE WELFARE PROGRAM IN THE STATE OF MARYLAND

Governor MANDEL. It is a pleasure to be here. Mr. Chairman, I have with me this morning Jack Kent, who is the secretary in charge of our program in Maryland.

Senator TALMADGE. We are delighted to have you here.

Governor MANDEL. I am representing the National Governors' Conference. I have, and I think it has been presented to you, a statement. I am not going to read that statement.

Senator TALMADGE. Without objection the entire statement will be inserted in the record and you may summarize it as you see fit, Governor.

Governor MANDEL. This is a unique problem and, I think, unique in several ways: First, that there is unanimity among all of the Governors in favor of repealing this section of the law because the Governors feel that it is a total infringement on the constitutional rights of the State.

As you know, a number of the States, including our own, are in court already on this very problem. We feel there is more involved here than just the question of reimbursement of a provision. There is a question of State sovereignty involved.

Not only that but I also feel, Mr. Chairman, that it goes a great deal further. This is just the first step in what could be a series of these types of amendments to bills that could involve us, wherever Federal funds are involved, in waiving our constitutional rights if we are going to receive Federal funds—roads program and all other programs.

There are countless thousands of providers to the State. We spend millions of dollars each year in buying services, buying supplies, from all types of providers, not just in this program. If every Federal program where there are Federal dollars involved were going to require us to waive this provision of the Federal Constitution, then you would be, in effect, destroying the very system of government, of State sovereignty, as we know it. We feel that this amendment is not only an infringement on that right; we feel it is totally unconstitutional.

There is a serious problem, a problem of escalating costs in this program. I think the Governors are as well aware of this problem as is this committee. All of us are trying to do something about it. We feel there are better solutions to the problem than what has been provided by this amendment in the law.

For example, in our own State we have two methods. In our program itself, in any administrative decision, a provider can appeal that decision to the secretary of health of our State. He can then appeal from there to a board of review that is an independent board set up consisting of consumers. He can have that right of appeal, which wouldn't take more than a month to be heard. From that board of review he can then go to our courts. So he has that one method.

But in addition to that, we have embarked on a program which we think that this committee ought to take a very hard look at because of the success that it has enjoyed. We created what we call a hospital cost review commission. The only way I can draw an analogy is to say that the hospital cost review commission is a public service commission for hospitals just as we have it for controlling utilities; we have one now that controls hospital costs.

Each individual hospital and nursing home has an individual hearing on its costs before the commission. The commission then sets the daily rate for the hospital, and the hospital has to abide by it. It also has the right to appeal to the courts.

To show you the success of how that has operated, from the last report on hospital costs by the Department of Labor Standards I

would like to read to you what has happened around the country in 10 of the largest cities. Hospital costs increased in Philadelphia, 23 percent; Detroit, 20 percent; Chicago, 19.4 percent; Los Angeles, 16 percent; San Francisco, 15 percent; Atlanta, 13 percent; Saint Louis, 11.7 percent; New York, 11.3 percent; Baltimore City, 3 percent.

The system is working. The hospitals and the nursing homes—and quite frankly, it is fairly new; we haven't gotten into the nursing homes yet but we are just proceeding with each individual hospital—it has been so successful that within the last 2 months I had a meeting in my office with the people from the social security, medicaid and medicare programs and they have now agreed to enter into a contract with the State for an experimental program to accept the costs as set by our hospital cost review commission as the costs that the program itself will accept.

Now we feel that there are far better methods available to control the escalating costs than by simply putting a provision of this type in the law that will cause endless controversy and endless cases in the court.

How do we explain, for example, to a public that is well aware of the escalating costs in this program that we are going to waive our sovereign immunity so that providers can sue us in court to get more costs into the program? It is very difficult to make the public understand that.

I am talking from a State, Mr. Chairman, which has just enacted a waiver of sovereign immunity for written contracts—in other words, with anyone who enters into a written contract with the State of Maryland, we have waived the right of claiming sovereign immunity, not because we feel that it is a right that we are giving up but because we feel the State has a moral obligation to carry out the intent of its written contracts.

But to require us to waive that sovereign immunity or face a penalty, we think is absolutely not only unconstitutional but it is the first step in what will be a long series of waivers that will be required. I am sure that if anyone came into this Congress with a bill that would say a recipient under this program had to waive his right to vote in order to receive any funds under this program, Congress would absolutely be in an uproar.

You are doing the same thing to the State. You are saying that you have to open yourself up for all kinds of claims merely because one State has a problem. We don't think it is fair to all of the States.

Senator TALMADGE. I take it you are speaking for the other 49 members of the Governors' Conference, and they are unanimous in this position.

Governor MANDEL. As far as I know, Mr. Chairman, they are unanimous and I think it is about the first time we have been unanimous on almost anything.

Senator TALMADGE. You have heard Secretary Kurzman's statement a moment ago and I want to read one particular paragraph of his statement and see if you share that view, and I quote:

> We would not object to a statute that deems continued State participation in the medicaid program to be a waiver of its immunity to suits by providers in Federal court. Such legislation would not place States in jeopardy of losing any medicaid funds because of State incapacity to act within a given period.

Governor MANDEL. I wouldn't agree with that. I, for one, and I can't speak for the rest of the Governors, I would waive it.

Senator TALMADGE. For the same reason you have outlined in your principal statement?

Governor MANDEL. That is right. I think it is the same problem.

Senator TALMADGE. If the States had discretion to pay hospitals less under medicaid than Blue Cross or medicare pays, wouldn't that further encourage a dual system of care, one for the poor and another for everyone else?

Governor MANDEL. I think it would, Mr. Chairman, and I think that is why in our State we have gone in the direction of providing a system for the hospitals and for the nursing homes where they have the right to appear before the hospital cost review commission and establish their rates.

Senator TALMADGE. Is that what you would recommend to assure uniformity and conformity with the Federal statutes and regulations?

Governor MANDEL. It has set that pattern, so much so that we had a meeting with Blue Cross, medicaid, medicare and Social Security in my office about 2 months ago. And they are now negotiating a contract with the State of Maryland for an experiment to show that they will accept the rates set by the hospital cost review commission as being fair and reasonable and totally in accord with the law.

If that works I think it is going to be a great moneysaver for the rest of the country.

Senator TALMADGE. I addressed your hospital association in Maryland about 30 days ago and complimented them on what they were doing in trying to save money and I was very much impressed with their efforts in that regard.

Governor MANDEL. There has been a total cooperation. As you know in the beginning everyone objects to control and regulation but at this point I think we are getting total cooperation.

Senator TALMADGE. Do you think we should give the States more discretion in the line of reasonable costs, of hospital costs?

Governor MANDEL. Yes, I do, sir, provided, and I say provided that there is a recourse of the provider if it is an unreasonable rate. I think they are entitled to a reasonable rate and I think they are entitled to fair reimbursement. I think they have to have recourse.

Senator TALMADGE. There are so many constraints on the budget now, Federal and State, isn't it possible that you would have 50 different payment rates in some instances under that type of thing?

Governor MANDEL. We will have different payment rates in our State now in each hospital depending upon their own costs, and as each hospital is examined by the hospital cost review commission there will be different rates.

Senator TALMADGE. Have you had an opportunity to study the bill which, along with some 16 or 17 other Senators, I have introduced?

Governor MANDEL. Mr. Kent has familiarized himself with that bill.

Senator TALMADGE. Are you prepared to make a recommendation on it at this time?

Governor MANDEL. I would like to ask Mr. Kent if he feels he is ready to make recommendations.

Senator TALMADGE. Will you please look at it carefully because we hope to have hearings on the bill later in this month. The problem,

as you pointed out in your testimony and Mr. Kurzman pointed out, is that this whole program is escalating in costs at the rate of about $7 billion or $8 billion a year. It is vitally necessary that we take some action at the Federal level to try to stop these enormous escalations in costs.

Governor MANDEL. There is no question about it, Mr. Chairman. We have to do it and the State has to do it and the Federal Government has to do it. The question is the mechanism to do it and how we can get at it.

Now, our costs are about $267 million. That is Federal and State funds, of which about $120 million will be reimbursable. We have a number of programs that are not reimbursed by the Federal Government. That cost has been escalating at a tremendous rate. There has to be some control on it.

You don't get control, however, by this type of amendment that we are talking out right now. If I can make a suggestion, you get control by eliminating the endless redtape that is inherent in the program today. Most of the mistakes and errors made in the program that are costing money are caused because it is so difficult to understand the rules, regulations and statutory limitations that the program is bound by.

I have been saying this now for, I guess, about 6 years, but if you expect a $8,000 or $10,000 clerk in trying to make this program work, to be able to understand all of the rules, regulations and interpretations, I might say that they are bound to understand in order to make it work, it is almost an impossibility.

The welfare program is the same way. You have a stack of regulations that are this high and you expect that clerk who is there working with them to understand them all and when he gets to understand them, they will change about 2 weeks before.

Senator TALMADGE. Thank you very much. It is a very impressive statement.

Senator DOLE. I appreciate your statement, Governor Mandel. I know he speaks for the Governor of Kansas. We are one of those 13 States which have not consented to suit. I would like to place in the record, Mr. Chairman, a statement my senior colleague, Senator Pearson, with reference to the bill he introduced, to repeal section 111, and then finally ask the Governor a question.

Senator TALMADGE. Without objection, the insertion will be made.

[The statement of Senator Pearson follows:]

STATEMENT OF SENATOR JAMES B. PEARSON

Mr. Chairman, I appreciate this opportunity to make a contribution to the Record. But first, let me compliment the distinguished members of the Subcommittee and, particularly, Chairman Talmadge for taking prompt and responsible action in convening this hearing.

Your attention is rightly focused on two tasks. The first is to relieve the States of the burden of the over-broad and unreasonably harsh provisions of P.L. 94–182. Having accomplished that, you can then turn to the more complex task of assuring adequate and timely reimbursement to medical provider participants under the Medicaid program.

With respect to these tasks, a cursory history of the offending legislation should be briefly noted.

The Social Security Act requires the providers of inpatient hospital services to be reimbursed on the basis of reasonable costs. All but four States follow a system of reimbursement identical to that used in the Medicare program. Under

this system a provider is paid at an interim rate during the accounting year with adjustments paid at the year's end. In the event, such as has occurred in Illinois, that a State freezes its interim rate at a low level and defers complete payment until the year-end adjustment, the provider is subject to difficult cash-flow problems. A provider faced with this action by the State has little recourse other than to turn to the complex and allegedly inadequate administrative remedies provided by the Department of Health, Education, and Welfare regulations. This theoretic problem, which, I am told, is very real in Illinois, created pressure for additional statutory remedies for in-patient providers. The legislative response to this need was a provision which became Section 111 of P.L. 94–182.

Under that section States are required to assure providers of inpatient hospital services access to Federal Court to contest the reasonableness of the State's reimbursement system. The States are required to expressly consent to suit in Federal Court with respect to the payment of reasonable cost of in-patient hospital services. The law also provides that a penalty of 10 percent of the total Medicaid funds otherwise payable to a State is to be applied in any quarter in which the Secretary finds that the State is not in compliance with these requirements. Additionally a strict timetable is set out forcing States to promptly adjust their plans to the new requirements.

One would have thought that this demanding legislation, which requires States to relinquish one of the very principles of sovereignty itself, would have been exhaustively deliberated before enactment. Unfortunately, such was not the case. Though designed to address an admittedly limited problem, this harsh and far-reaching provision was passed without much consideration at all.

In the Christmas rush, in fact on the last day of the past Session, the House approved Section 111. This was done without the benefit of responsible Committee consideration in either House. Not as much as a paragraph in the reports on the encompassing legislation was available to give members any opportunity to consider the ramifications of this last minute measure. No evidence was adduced to support the reasonableness of the timetable for compliance; no estimates were made of the volume and cost of foreseeable litigation; no testimony was offered to justify the severity of the penalty provisions; and, most importantly, no adequate rationale was articulated as to the necessity for complying States to waive their sovereign immunity.

Whie the law has been with us for nearly seven months, all the facts are still not available. What we do now is that most States cannot possibly meet the deadline for compliance. We know that at least 12 States consider the law to be unconstitutional and have brought suit to enjoin the Secretary from taking action under its provisions. We have some idea of what the cost of non-compliance is. In Kansas, they tell me the cost of refusal to waive could be as much as $24 million this year. That would mean 60,000 patients might be denied services. But we still don't know how much the States will have to spend in litigation and for increased reimbursement costs. We also don't know what kind of precedence the waiver provision constitutes for others who have business dealings with the States. In fact, we don't even fully understand the impact of this type of legislation on the delicate Federal-State relationship.

To be brief, we are still in the dark about the advisability of this legislation. We should not have acted so precipitously. Recognizing our error, we should now squarely address that mistake and correct it. For that reason I have introduced a repealing measure. My statement on the bill can be found at the conclusion of my remarks. The House has already passed a similar bill.

Repeal will give us the time to study alternative, and less high-handed, solutions to the problem of assuring proper compliance with reimbursement plans.

It is encouraging to find that this Committee and corresponding Committees in the House of Representatives are now developing a record which will undoubtedly generate thought and information directed at solving reimbursement problems. It may well be that some legislation will be needed to rectify system abuses. But the more immediate task is to remove the ill-considered and hastily enacted law that jeopardizes vitally important Medicaid funds.

[From the Congressional Record, Apr. 12, 1976]

Mr. Chairman, the bill which I introduced on April 12 of this year, S. 3292, would correct a legislative oversight that threatens the fiscal security of our States and jeopardizes delivery of services to hospitalized medicaid patients. After Senate passage of the Social Security Act amendments last December the House inserted language, apparently without adequate consideration, requiring States to waive their immunity under the 11th amendment of the Constitution

in order to fully participate in Federal financing of medicaid services. I am certain that our members, frustrated by delayed action in the other body, did not then comprehend the complete ramifications of this legislation. Now that time has allowed a more thorough examination of the provisions, I believe a majority in both Houses will expedite this measure to rectify the error.

Under Public Law 94–182, section 111 a State plan for medical assistance must now include a consent to suit with respect to payment of inpatient hospital services and a waiver of any immunity from such suits. The law specifies that a penalty of 10 percent of the amount otherwise payable to a State for medicaid services will be exacted for any quarter in which the State is in noncompliance. The penalty provision applies for quarters beginning on or after January 1, 1976. The States are put in the quandary of either abdicating their constitutional position as sovereigns or losing substantial funds vital to their citizens' well-being. Should Kansas, for example, refuse to waive its immunity, the immediate impact could cost the loss of approximately $24 million. This might well necessitate discontinuance of medical programs with a resultant loss of services to approximately 60,000 patients. On the other hand, compliance with the law would mean abandoning a principal element of sovereignty itself. The consent and waiver of immunity will allow medicaid providers of inpatient hospital services to bring suit against the State in Federal court with respect to reasonable costs for services. Extensive and costly litigation would follow. Through this avenue medical service providers will pursue additional increases which could lead to extensive demands on State funds.

Mr. President, the legislation just introduced simply returns the law to its former status. There seems no justification for any change. No hearings were conducted; there is no evidence to justify such a substantial alteration in this sensitive program already beset with fiscal problems. It well behooves us to quickly correct this incursion into the constitutionally protected rights of our States.

Senator Dole. Do you have some recommendation on some effective means of resolving these compliance questions in a timely fashion that do occur between the Federal and State level?

Governor Mandel. I think there is one thing you can do. I think under existing law, if the State is out of compliance they have to withhold the entire amount of dollars available for the program. This I think the Department is reluctant to do because that is a tremendous impact on a State if you withhold all of the funds.

I think there could be a reduction in the amount to be withheld if they are out of compliance to make it a more realistic figure. In that way the Department would, I think, tend more to enforce compliance. But today when you lose all of the money, even the Department is reluctant to impose that harsh penalty on the State.

Second, I think there ought to be or there could be some mechanism where within the State, there could be final resolution of a question of noncompliance. I don't think it necessarily has to be in the Department. As I said earlier, we have a board of review where a provider can appeal at the administrative hearing to a board of review totally without the purview of the Department, a citizen board.

They hear it within 2 weeks to a month and appeal from the administrative action of the Secretary. They then give a decision. If that decision again is not agreed to by the provider, he can then go to our court and there is a record established for the court. The hearing will be based on that record.

So they have a mechanism to solve these problems. But I don't think the way that it is trying to be solved in the law right now by waiving the constitutional right of the States, that is not going to achieve it.

In our State, for example, and I can say it now, not only do we feel we don't have the right to waive it, that can only be done by the leg-

islature, I don't think our legislature would waive that right to be in compliance with this particular section.

Senator DOLE. I think you have offered some reasonable alternatives. I can't speak for all of the Governors on that but I think you are absolutely correct as far as the waiver provision is concerned.

Senator TALMADGE. Thank you very much, Governor. We are very happy to have you with us.

[The prepared statement of Governor Mandel follows:]

TESTIMONY BY GOVERNOR MARVIN MANDEL

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today, representing the National Governors' Conference, in support of H.R. 12961, which would repeal Section 111 of P.L. 94–182. On December 19, 1975, P.L. 94–182, amendments to Medicare and Medicaid, were approved by the Congress of the United States and subsequently signed into law by the President on December 31, 1975. Section 111 of that law amends Sections 1902 and 1903 of the Social Security Act (U.S.C. 1396, et seq). This law requires that the individual States waive their Eleventh Amendment immunity to suits in the Courts of the United States effective to January 1, 1976. The waiver is to be included in the State's plan for its administration of the Medicaid program. The law also provides that any State which fails to amend its state plan for its administration of the Medicaid Act to include this waiver shall be penalized 10 percent of the federal share of its Medicaid expenses.

In Maryland, 10 percent of the federal share of the Medicaid expenses for the first quarter of the calendar year 1976 amounts to $2,957,135. The State of Maryland commenced participation in the federal Medicaid Act in 1967. The Maryland law regulating state conduct of the Medicaid program is contained in Article 43, Section 42a. While many changes have occurred in the Medicaid program since its passage more than ten years ago, only this one seeks to strip the States of their sovereign immunity.

The problem before us today is unique. The Governors of the fifty States see this controversy not as one pertaining to the administration and reimbursement under the federal Medicaid program, but one as an intrusion into the inherent constitutional rights of the sovereign states. It goes straight to the heart of the relationship of the state and federal government.

What is involved is more than simple respect of one sovereign for another. The basic reason for sovereign immunity is to protect the State when it is engaged in the people's business. The social compact of a State's citizens with their government is struck in the statutes and constitution of each State. Relationships between private parties and their state governments are created and maintained in an atmosphere drawn by mutual understandings. Where the success of a relationship compels waiver of immunity from suit, the legislature may be relied upon to so act. However, this determination should flow from the dynamics in each State, not nationally mandated by the Federal Congress.

The question also arises as to costs and orderly processes. Are the courts to determine the circumstances of review of bills submitted by suppliers? Are the States to charge their own citizens for the costs of batteries of lawyers to answer complaints? How do we explain to our citizens who now complain about runaway costs of services to the poor that we are adding to the costs of the programs? This is hardly so popular a program that optional costs can easily be accepted by the citizens of each State.

States make hundreds of millions of dollars of purchases of goods and services every year—without the suppliers demanding waiver of immunity. Why do hospitals, pharmacies, nursing homes and physicians merit so special a status? They are free to participate in doing business with the State exactly as do road contractors and the firms which sell us autos, office equipment and fuel. They know, when they enter into the relationship, that they will be an equal status with all other suppliers. There is no reason why they should now be entitled to privileged status. The Governor and the legislature know the circumstances which elicit participation and they can gauge the circumstances which encourage reason among suppliers. They have been in business longer than has the Federal Government and they manage their finances at least well. If there are isolated examples of difficulties between States and suppliers, they should be resolved at the state level. It would contribute little to the nation's scheme of things to patch up a system in one State simply to see one or more other States withdraw from

the whole program on an issue of principle or because their legislatures do not meet until next year and may refuse to waive their immunity.

The nation's Governors also face rapidly increasing Medicaid costs which are threatening the fiscal integrity of the States. States must act to reduce the rate of increase in Medicaid costs without holding the medically indigent hostage to forces beyond their control. I anticipate that the Governors will commit themselves when they meet next month to an all-out effort to examine the current Medicaid program with anticipation of comprehensive reform. The Governors are committed to providing the poor with sufficient health services, however, they cannot jeopardize their constitutional and legal integrity to comply with poorly conceived "quick fixes" growing out of isolated problems.

Senator TALMADGE. The next witness is the Honorable Richard Daley, the mayor of the city of Chicago, accompanied by Mr. Julian Levi, and the Senator from Illinois, Mr. Stevenson, is recognized.

STATEMENT OF HON. ADLAI E. STEVENSON, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator STEVENSON. We are very grateful to you, Senator Talmadge and all of the members of the committee, for these hearings and I commend you for your diligent attention to the medicaid reimbursement compliance problems which are bedeviling citizens and units of the Government across the country.

Chicago has the well-deserved reputation as a city that works. That reputation is owed in large measure to the skill of its chief executive. Mayor Daley needs no introduction. He is a legend. He is here this morning on behalf of the citizens of Chicago, who can speak with authority on the subject of these hearings. The problems in Chicago are not unique. They are everywhere in the country.

So, Mr. Chairman, I am confident you will find his testimony of value to this committee and it is a great pleasure to introduce the mayor of Chicago, Richard Daley.

Mr. TALMADGE. We are honored to have you, Senator, and we are honored to have Mayor Daley with us.

STATEMENT OF HON. RICHARD DALEY, MAYOR OF THE CITY OF CHICAGO, ILL., ACCOMPANIED BY JULIAN LEVI, CHAIRMAN OF THE CHICAGO PLANNING COMMISSION

Mayor DALEY. Thank you Senator Stevenson, Senator Talmadge, and Senator Dole. I appreciate very much the opportunity to appear before this distinguished subcommittee in order to give my views on a subject which is very important to the health care of the people throughout the country.

This hearing pertains to section 111 of the Public Law 94–182. This section requires the State to formally waive its constitutional immunity to suits involving payment under medicaid for inpatient service. If a State fails to waive its immunity, it is subject to a reduction of 10 percent of the Federal share of medicaid costs.

It is my opinion that the repeal of the requirements that a State waive its immunity to substitute in disputes involving payment under medicaid will be very deterimental to the health and care of our people and particularly senior citizens.

Congress enacted medicaid to provide medical assistance to persons most in need. This program has been administered through the States.

Citizens eligible for medicaid have been treated and the providers of this health care have been reimbursed through the State with Federal funds to the extent of at least 50 percent.

Responsibility for overseeing the efficiency and effectiveness of the medicaid program rests with the United States Department of Health, Education, and Welfare. The problem is that somewhere along the line, HEW in some States has failed to carry out the congressional intent that the objective of the medicaid program is to make certain the poor receive medical care of a quality not debted by their pocketbooks.

Medicaid provides money for medical care for the poor. It is not a program to benefit hospitals and the hospitals of Chicago have never viewed it as such.

It is a program to provide health care for citizens, most of whom happen to be welfare recipients.

If the providers of this care are not reimbursed for their services, then the result is that medical care needed by the poor is not provided. That is what is happening in our community.

HEW admits that this is a national problem not confined to any single State. In Illinois, for example, the objective of the program to care for the poor or ill has been ignored. The State has frozen the level of reimbursement as of last October.

The State has been indifferent to the fact that the providers of health care have been faced with increasing costs for which, under medicaid, they are entitled to reimbursement.

The Chicago Hospital Council has warned that at least eight Chicago hospitals are fighting to survive. Their struggle has been brought about by the refusal of the State of Illinois to comply with the law and the failure of the Department of Health, Education, and Welfare to enforce it.

Among the hospitals in Chicago which might be forced to close because of this neglect by State government are Englewood, Cabrini, Mary Thompson, Chicago Osteopathic, Roosevelt and Norwegian-American, Salvation Army and the Cook County Hospital.

The financial constraint caused by the freeze has been experienced by all hospitals treating medicaid patients and 21 percent of all hospital admissions in Chicago last year involved Medicaid patients.

Some hospitals have been forced to cut back on their services and, worse of all, some of them have been forced to reduce the number of medicaid patients they treat.

Mercy Hospital in Chicago has reduced their medicaid patient load from 29 to 25 and have reduced the area of the city from which it will take any patients.

Illinois Masonic Hospital reports it will lose $900,000 this year because of the State freeze. It, too, will reduce patient load.

Saint Luke Medical Hospital in Chicago made a similar reduction, estimates it will lose between $3 million and $5 million and will not accept any new medicaid patients for outpatient care.

Perhaps most serious of all is the effect of the cash flow shortage of the Cook County Hospital. Just this week, Mr. Chairman, of the $14 million owed, the State agreed to pay $8 million to keep it open. It was threatening to close and that is our great Cook County Hospital.

The medicaid program which Congress enacted is being thwarted by

governmental officials at State and Federal levels who refuse to see to it that the objective of the Congress to provide medical care for those in need is carried out.

This is not a dispute between the hospital and the State. It is governmental indifference to people in need. No wonder people are losing confidence in Government. They know that this chicanery does not have to happen.

The medicare program operates through the States, but HEW should be concerned about what has happened in the counties and cities of America where the people live who need this medical care.

In the instance of Illinois, the State has violated the Federal law pertaining to reimbursement, but HEW has done nothing about it.

It is very important that the provider of medical care not suffer the loss of section 111, the requirement for the State to waive its constitutional immunity to suit. If this requirement would be repealed, many hospitals throughout our country would be in jeopardy and the poor who receive their services would be untreated.

I believe that there should be an elimination, however, of the provision of section 111, saying that if a State fails to waive its immunity, it is subject to a reduction of the Federal share of medicaid.

A State in such a situation should be subject to other legal penalties, other than a reduction of medicaid funds which would ultimately hurt the people rather than the States.

More important than all of this is the role of the Department of Health, Education, and Welfare. No provider of medical care service for the poor should ever have to seek recourse in the courts for reimbursement from the State.

This need not happen if HEW does its job. The failure of HEW in this instance is an example of the recurring theme of the Federal Government of the inability or outright refusal of Federal departments and agencies to carry out the intent of Congress in legislation which has been enacted by the Members of the Congress.

We don't want hospitals to have to go to court for reimbursement. We want HEW to make certain that the program works so that the elderly, the children, the poor and all other people this program was intended to help receive necessary and proper medical care.

I thank you, Mr. Chairman, for the opportunity of appearing.

Senator Talmadge. The Chair recognizes at this time the distinguished junior Senator from Illinois, Mr. Charles Percy.

STATEMENT OF HON. CHARLES H. PERCY, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator Percy. I merely wish to take a moment to express our appreciation to Mayor Daley for being here and to our colleague, Congressman Dan Rostenkowski for coming over here from the House and to Julian Levi.

I have worked with Julian Levi for 25 years and with the mayor, trying to save the south side of Chicago. I am glad to have his energy now with the mayor trying to save the hospital system of Illinois.

The mayor, who is so articulate and has spent his lifetime defending the interests of the poor, the impoverished, the children and the elderly speaks with deep feeling this morning as we have had to have our Cook County Hospital borrow $25 million to stay afloat. Where we

see, because of bureaucratic problems and the problems with the State, Illinois hospitals lose this year $80 million in revenue that they, in my judgment, should be collecting.

Mr. Chairman, we thank you for an early response to the bipartisan letter that Senator Adlai Stevenson and I sent, together with Senator Taft, in having these hearings focus attention on this particular problem to see if we can't overcome it.

We certainly welcome the mayor here and wish to assure him that his congressional delegation stands solidly behind him.

Senator TALMADGE. We wish to acknowledge the presence of Congressman Daniel Rostenkowski from the city of Chicago, who also is chairman of the Subcommittee on Health of the Ways and Means Committee of the House of Representatives. Congressman, would you care to be heard?

STATEMENT OF HON. DAN ROSTENKOWSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Representative ROSTENKOWSKI. Mr. Chairman, it is always a pleasure to join with my colleagues in this body and I am certain that I reflect generally the delegation's sentiments with respect to this legislation.

I can add very little to what has already been said. I want to express my deep gratitude to Senator Talmadge, the chairman of this subcommittee and the gentlemen that are taking the time to listen to this problem that we have in Illinois.

It is a situation that needs immediate attention because we do have a solvency problem with respect to our indigent in this State. Certainly, the mayor has expressed the problem that we face and any expeditious meaning that you can give to this very important legislation we gratefully appreciate.

Senator TALMADGE. Thank you very much. Is there a fiscal crisis in Illinois, Mayor Daley?

Mayor DALEY. I think there is, sir. In other words, you can't spend more than you take in too long without being in trouble.

Senator TALMADGE. I can appreciate the fiscal problems facing the States which are already imposing heavier tax burdens on their citizens.

How does Illinois tax efforts, say sales and income tax rates, compare with those in other large cities?

Mayor DALEY. I would say this, Senator: We haven't had an increase of any kind in 4 years and with the cost of labor increasing and inflation, it is necessary that the cost of government increase.

I, as mayor, have never ducked a question. If we need more money for what we are doing, we have to go to the people and ask for it. I think many public officials fear that on the basis that they are always told that an increase in taxes means the end of their political career. If that were true with me I would have been ended a long time ago.

But, I think what you have to do is to make sure that our Government is properly administered, to solve the management problems that there is no inefficiency.

There is always going to be a percentage of it, but I think we have too much inefficiency in all types of government, starting at the local, State, and Federal Government. It is the inefficiency in the government and management that the people want to see in a better way.

I don't think the people of America want the Congress, the Governors or the States or cities to eliminate these programs. I think the people of our country want better administration from everyone. I don't single out any.

I haven't heard any argument on HEW or anyone else. I think this is something that has grown in our country and we have to address ourselves to take a lot of the waste and inefficiency in government out of it. I think it can be done.

Sentor Dole. What recourse do hospitals in Chicago now have to challenge reimbursement without benefit of section 111?

Mr. Levi. We are in a jurisdictional thicket. Let me describe what the situation is.

Without section 111 the following develops, Senator. First, recourse will have to be only in the State courts. Second, under the State act, monetary damages may be awarded only in the Illinois Court of Claims. Third, determination in the Illinois Court of Claims is not available until all administrative, legal, and equitable recourses have been exhausted. I am quoting the statute.

Thus, a claimant must proceed in circuit court under the Administrative Review Act, but assuming he is successful in circuit court then if his appeal is sustained, monetary damages cannot then be awarded to him.

Finally, the Illinois Court of Claims has a 5-year statute of limitations except as to claims under public aid and these are those claims where the statute is 1 year.

Hence, the State is in a situation where it can have easily prolonged, as it has, any of these procedures for years. Assuming it turns out that they are wrong and it takes 3 years to settle it, 2 out of the 3 years will be outlawed by the statute of limitations.

Unfortunately, Senator, as I have in a briefing book here expressed references to the statute and to the decisions of the Illinois courts of review and in the key cases denial of certiorari to the U.S. Supreme Court.

I can add only one other thing. My competent State attorney general will be able to delay these matters even further because he will find some way in which Federal court jurisdiction will have to be involved at some point.

So, we will not even get into the miserable charade I have described to you until after that is over. So that, as a practical matter, if section 111 is repealed, these hospitals are left without any remedy whatsoever.

Senator Dole. I don't know whether you have listened, Governor Mandel, and I don't know how you mentioned you do it in Maryland, but they have a review board and therefore he feels that at least in that State they can accomplish the same thing without section 111.

Has the State of Illinois done anything like that?

Mr. Levi. May I read you two or three paragraphs on some research I have done?

It has often been said that modern medical education and training in the United States began at the medical school of Johns Hopkins University in Baltimore, Md., and I think it is a fair statement that there is a deep and continuing national interest in the welfare and future success of that institution.

I am told that the State of Maryland in its administration of the medicaid and welfare programs reimburses Hopkins for professional services rendered, but its faculty at a rate 50 percent less than that approved for medicare and administers reimbursement for the costs of the emergency clinic run by Hopkins in such a way as to impose a $3 million a year loss on the medical center and the university.

Generally, Maryland, I am told, has carried as much as $25 million a year in bills past due and unpaid to providers of health care. It is, of course, understandable that anyone in that position would seek to deny a legal remedy to those to whom such sums were owed.

Senator DOLE. I am advised the hospitals of Maryland are generally satisfied with that.

Mr. LEVI. They are not. What is happening is that medical education in this country is taking a terrible beating as a result of this. The other thing, of course, that happens in a situation of this kind is that then, contrary to the intent of Congress, private patients, Blue Cross patients, get hit with these charges.

The wisest comment that I know that was made about this was the comment of a very courageous great man when he stood on the floor of this Senate on March 25 and said,

> Mr. President, it is time, in fact past time, to put our house in order. To do that hard decisions have to be made and if these decisions are not made now we will be confronted with the need to cut and slash patients to hospitals and doctors indiscriminately and often inequitably.

Of course, Senator Talmadge will recognize his own words. This is what we are up against here. This is what this is all about.

This bill does not involve anything regarding the validity of any claim at all. It is simply to keep the door of the courtroom open so that the hospitals are not completely victimized.

There is one other point. Assume that you have an account payable from the State and in all honesty you have to tell the bank,

> I am not going to be able to bring a lawsuit on this claim and if I do and it is prolonged longer than a year I am going to lose. I may wind up 3 years down the pike with the ability to enforce 1 year.

No responsible backer will loan on those funds. He shouldn't.

Senator TALMADGE. Mr. Levi, is there a reasonable alternative to this dilemma without requiring the States to waive their constitutional immunity they are guaranteed under section 111 of the Constitution?

Mr. LEVI. I don't see it at this point, Mr. Chairman. For one reason, and that is that when I look at the record of HEW in this situation I am simply dismayed.

What has happened here, for instance, is this: This has been a long time coming.

On October 6, the Illinois Department of Public Aid told all hospital providers of medicaid in Illinois that they had to agree to an alternative reimbursement plan. On January 8, the regional office of HEW found the alternative reimbursement plan arbitrary and

illegal. It disapproved the plan and it told Illinois to continue to reimburse providers under the earlier State plan.

The record of this and the letters, of course, are in the possession of your very able staff person, Mr. Constantine, with whom I have worked on this.

The State of Illinois then sought review of this decision by instituting suit in the Federal District Court against the regional director and the secretary of HEW. In this record, which I have put before you, there is an affidavit signed by people of the State in support of a motion for injunction saying they were told by HEW that his was a violation. Nothing happened.

On March 27, the Secretary of HEW responded at the urging of the two Illinois Senators and said this is going on and we understand there is violation. He responded by saying he has committed the care of this thing to some of his subordinates and that he cannot comment on the details or merits of the proposal, even though the regional commissioner had refused to approve the alternative plan.

Then, on behalf of HEW, the U.S. district attorney files an answer in Federal court again asserting the illegality of the State plan.

HEW took no action whatever to secure compliance, even though the State was then before the Federal court and the State, I guess, decided that this was really a toothless monster they didn't have to bother about. So, they dismissed the case.

To this day, the Illinois Department of Public Aid continues to administer this federally assisted program in deliberate and notorious defiance of law without any interference whatsoever from HEW.

HEW, when it is pressed on this, says the only thing they could do would be to cut off all funding and that is far too great. I do not think that there ought to be any cutoff funding. You hurt the very people that you try to help. But, there simply is no substitute for the discipline of the court.

We are in a situation here where all you have to do is look at the level of expenditures made in Illinois and you see this peculiar bulge before the last Illinois primary, and let us face it, the State was administering this program for political reasons.

Senator TALMADGE. Thank you very much and we appreciate your contribution, Mayor Daley.

The next witness, the Honorable Robert List, attorney general of the State of Nevada, representing the National Association of Attorneys General.

We are delighted to have you with us.

STATEMENT OF ROBERT LIST, ATTORNEY GENERAL OF THE STATE OF NEVADA, REPRESENTING THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL AND CHAIRMAN OF THE COMMITTEE ON HEALTH

Mr. LIST. My name is Robert List and I am the attorney general of the State of Nevada. I am also here in my capacity, Mr. Chairman, as the chairman of the National Association of Attorneys General Standing Committee on Health, Education, and Welfare.

I apologize for the fact that I don't have prepared written remarks. My appearance here today frankly is prompted by the adoption of a resolution the day before yesterday by our full association meeting in San Antonio concerning the subject that this committee has under deliberation here.

I will give you a copy of that resolution.

Senator TALMADGE. Without objection, the resolution will be inserted in the record at this point.

[The resolution referred to follows:]

RESOLUTION VII

RESOLUTION IN SUPPORT OF REPEAL OF SECTION 111, PUBLIC LAW 94–182

Whereas, the Executive Committee of the National Association of Attorneys General on April 12, 1976, adopted the following resolution: Be it

Resolved by the Executive Committee of the National Association of Attorneys General that the Secretary of the Department of Health, Education, and Welfare be requested, in the strongest possible terms, to urge Congress to repeal Section 111 of P.L. 94–182 as being an improper intrusion into the constitutional and appropriate authority of the States.

Whereas the House of Representatives on May 12, 1976, passed H.R. 12961 which would repeal the provision of P.L. 94–182 requiring the States to waive their Eleventh Amendment protection in suits in federal court by providers of certain medicaid services or suffer a 10% penalty in federal share of medicaid funds; and

Whereas federal fiscal sanctions and penalties of this nature are difficult to invoke, disruptive of program objectives and harmful to program recipients: Now, therefore, be it

Resolved, That the National Association of Attorneys General urges the United States Senate, and its appropriate committee, and subcommittee, to act promptly and favorably on the pending bill to repeal Section 111 of P.L. 94–182 (requiring the states to waive their Eleventh Amendment immunity to suits under the medicaid program brought by health care providers in the federal courts), and not to delay consideration of that bill because of other issues awaiting Congressional consideration; and be it further

Resolved by the National Association of Attorneys General, That it pledges its cooperation and the cooperation of its members in working with Congress to develop alternatives to fund cutoffs and fiscal sanctions as effective methods to promote compliance by the states with applicable federal requirements.

Resolved unanimously this 5th day of June, 1976.

A. F. SUMMER,
Attorney General of Mississippi, President.
FRANK H. BAILEY,
Secretary of the Association.

Mr. LIST. I, like most of my colleagues in the association, do the legal work for the State agencies which administer title 19 programs. Therefore, of course, most of us are familiar and work on a daily basis with the legal problems surrounding medicaid.

Specifically, of course, this act provides for some very fundamental services to the people in our States. It is really, I think, at the very crux of why we all serve and that is to help those who are unable to help themselves.

In my little State of Nevada, we have only 21,000 recipients but to us that is a good many people. We get approximately $12 million of Federal aid each year and, of course, that is a large amount of money to our little State.

After this amendment was passed in December of last year and the notice was sent out to the various States that it would be necessary to waive the section 111 amendment if we were to continue to receive

the full amount of money, the reaction began all across the country in the attorney general's office as well as in the bureaucratic agencies which handled these Federal funds.

I might say, it was a violent reaction even at a level where redtape is certainly no stranger and in the department where it is no stranger. That reaction went all of the way up to the chief legal officers and as Governor Mandel mentioned the chief executives of each State.

I can say without equivocation that we viewed this section 111 of the bill as an amendment by Congress to coerce the sovereign States of this Nation into abandoning their rights guaranteed to them under the 11th amendment of the U.S. Constitution.

The section, of course, provided that failure to comply would mean a loss of 10 percent of our Federal funding and that varies from State to State, but certainly it is significant, a vastly significant amount in every State.

If I may, I am going to analogize to another area of law with which by background I am more familiar and that is the area of criminal law. I think it is a little bit like the old sheriff who says to a suspect,

Either you waive your rights to an attorney, your constitutional rights to an attorney and to a trial by jury, or you are going to get your arm cut off.

That is just about what this bill says. You waive your constitutional right to have your disputes with your citizens tried in your own courts or you are not going to get that 10 percent.

By any measure, that certainly is duress and it is coercion. I don't think anyone ever said it better than Chief Justice Stone who said that the threat of loss, not hope of gain, is the sense of economic coercion.

As a result of the coercion of this act, Mr. Chairman, the various States proceeded in court. Of the 50 States, approximately 14 are engaged in litigation with the Federal Government over this issue. I dare say there would be a good many more were it not for the fact that a temporary restraining order was entered in the Kentucky litigation which in effect stayed the imposition of this penalty until the outcome of the litigation.

I think probably the case which is most advanced is a case here in the District of Columbia, initiated first by California and later joined in by a good many other States and also consolidated with a case brought by Pennsylvania which has a number of other States as plaintiffs.

In that litigation it was argued that this coercion was in fact unconstitutional and that the bill in question or rather section 111 which is here before this committee today, is unconstitutional.

The court has taken that under advisement. It is a three-judge panel, and obviously it is of great interest to all of the States in America.

None of us can stand to lose those funds. I think what we are suggesting to the court, and I certainly don't presume to prevail upon this body by imposing legal arguments here, but what we are suggesting is that we have here a unique imposition by the Congress of the requirement of the waiver of rights guaranteed to the States under the Constitution.

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Governor Mandel alluded to that and I might add that those of us in the Attorney Generals Association have asked ourselves, "Where is this to stop?" If this precedent of requiring the waiver of constitutional rights by a State is to be extended into other areas of legislation, there could be virtually no limit.

In order to receive transportation funds, it could also be required that we waive the 11th amendment. In order to receive LEAA money, it could be required that our States or citizens waive their rights to keep and bear arms under the 2d amendment.

I suggest to you that it is a grave and very fundamental issue which faces this committee and which faces your full committee and the Senate itself, and that is whether or not the Congress as a string or condition to the granting of public funds, is going to require States to waive constitutional rights.

I don't think and in fact I know that none of my colleagues would advocate such a condition and we have strenuously urged swift passage of this measure.

Senator TALMADGE. Let me see if I can summarize your testimony, now. You are in favor of repealing section 111, which mandates that a State waive its rights guaranteed by the Constitution, amendment No. 11?

Mr. LIST. That is precisely it.

Senator TALMADGE. You are opposed to the portion of the act that permits them to withhold 10 percent of medicaid benefits if they are not in compliance?

Mr. LIST. We are.

Senator TALMADGE. What reasonable alternative would you suggest as an alternative to resolve these matters?

Mr. LIST. In most States, Mr. Chairman, they can be resolved in the State courts, as Governor Mandel indicated. The administrative remedy lies in his State and it lies in my State as well as the judicial field.

Senator TALMADGE. You heard Mr. Levi's testimony.

Mr. LIST. He indicated there is a certiorari method available in Illinois, and that one runs the risk of running into the statute of limitations. I suggest that that should be cleaned up and certainly the Congress I think could require that a State make a showing that there is a due process vehicle available to resolve disputes between providers of health care and the States. Most States have it and it is available. Let Illinois come forth and propose a method within their own jurisdictional boundaries by which the disputes can satisfactorily be resolved.

Senator TALMADGE. What would you do with a State that didn't make that showing or couldn't make it?

Mr. LIST. I suppose I would curtail their funds because certainly a provider is entitled to be paid. We wish to pay our bills. As a matter of fact, it might interest the chairman that we have had one law suit in Nevada by a provider. He brought a suit in Federal court and we lost. It is on appeal now, but if we lose it there we will pay the bill.

Senator TALMADGE. If the attorneys general have any suggestion along that line, I would appreciate your submitting it to our staff.

I appreciate your testimony and I take it you are speaking in behalf of all other 45 attorneys general of the respective States.

Mr. List. Yes; I am. For the record and my apologies for my having not done it earlier, may I introduce the Washington counsel for our association, Mr. Ray Marvin. We appreciate the opportunity to appear.

Senator Talmadge. We appreciate your contribution, Mr. List.

The next and final witness is Mr. Jeffrey C. Miller, deputy director for medical programs of the Illinois Department of Public Aid, and Mr. Verne Evans, general counsel of the Department of Public Aid of the State of Illinois.

We are delighted to have you, Mr. Miller, and if you desire, you can insert your full statement in the record and summarize it.

STATEMENT OF JEFFREY C. MILLER, DEPUTY DIRECTOR FOR MEDICAL PROGRAMS OF THE ILLINOIS DEPARTMENT OF PUBLIC AID, ACCOMPANIED BY ROBERT G. WESSELL, CHIEF ASSISTANT TO THE DIRECTOR; VERNE EVANS, GENERAL COUNSEL OF THE DEPARTMENT; AND GEORGE GRUMLEY OF THE OFFICE OF THE ILLINOIS ATTORNEY GENERAL

Mr. Miller. My name is Jeffrey C. Miller. I am the deputy director for medical programs of the Illinois Department of Public Aid. Accompanying me are Mr. Robert G. Wessell, chief assistant to the director; Mr. Verne Evans, general counsel of the department; and Mr. George Grumley of the Illinois Attorney General's Office.

My testimony today will focus on actions taken by the State of Illinois to control hospital costs.

Health care costs in this country have increased alarmingly over the past several years; Illinois, along with most other States, has been hard hit by these increases. In fiscal year 1970, total medicaid spending in the State was $205 million; by fiscal year 1975, this had increased to $711 million. Thus, in the 5 years from 1970 to 1975, medicaid spending more than tripled.

Hospital care is the sing'e largest component of the Illinois medicaid budget—an estimated $308 million, or 40 percent of the current fiscal year's expenditures. Thus, any effort to contain costs in medicaid must include provisions for controlling the upward spiral in hospital costs of the last several years.

Therefore, the Illinois Department of Public Aid created the Hospital Reimbursement Review Board on October 8, 1975. This board was directed to undertake two critical tasks:

> First, develop an equitable system of reimbursing providers of inpatient and outpatient hospital services that contains incentives for the efficient, economical delivery of such services, and
>
> Second, recommend an interim reimbursement methodology to be used until the new system can be implemented.

The sanction of the regional office of the Department of Health, Education, and Welfare was sought by letter of October 6, 1975. The initial response from the regional commissioner, SRS, stated, "We are unable to determine the acceptability of the proposal in its present form."

A further exchange of letters culminated with the regional commissioner concluding that the information provided was not sufficient for a determination of the acceptability of the Illinois proposal to be made.

The Hospital Reimbursement Review Board was actively engaged in fulfilling its responsibilities in the midst of these efforts to clarify its authority.

On January 15, 1976, the board forwarded recommendations for interim reimbursement rates, developed after extensive analysis of per diem costs incurred in the last 3 fiscal years. Hospitals were initially classified by size and geographic location; they were then further separated based on the degree of university affiliation. The board recommended that reimbursement be established at the lowest of the following rates:

The average fiscal year 1975 per diem cost of the group, plus 3 percent; or

The hospital's fiscal year 1975 per diem cost, plus 3 percent; or

The hospital's 1973 per diem cost plus the average cost increase experienced by the group, plus 3 percent.

Although the Department approved the proposed rates, they have not been implemented. Without prior Federal approval implementation of these rates would jeopardize Federal financial participation in the medicaid program in Illinois.

One further attempt to secure DHEW approval—directly from the Secretary—was unsuccessful. Thus, no interim rate adjustments have been made in Illinois for hospital inpatient or outpatient services since October, 1975. It is important to note that reconciliations have continued as in the past—that is, based on audits of hospital records at the end of their fiscal year, payment of full allowable costs have been made.

The board has also made considerable progress toward accomplishing its primary purpose; the development of a new reimbursement methodology for use by the State. A final proposal is expected from the board by the end of this month. Although no final recommendations have been made by the board, several important aspects of the proposed new system have been tentatively identified.

First, reimbursement rates will be established prospectively. Prospective rates, properly developed, provide incentives for the efficient, economical delivery of quality care.

Second, hospitals will be classified into groups to provide a basis for valuating the reasonableness of patient care costs and the efficiency with which providers render health care services. Proposed groupings, based on geographic location, type of hospital, size, and the volume of medicaid business, have been formulated. Comments from the hospital industry are being solicited at the present time concerning these proposed classifications.

The precise rate setting methodology—the heart of the board's efforts—is currently in the final stages of development. Prospective rates can be established by formula, negotiation, or review and approval of a proposed budget. The basis of payment—total hospital budget, departmental budget, per case, per diem, et cetera—must also be determined.

Uniform accounting budgeting and reporting will be required of all participating hospitals. Monetary incentives to efficient operations will be included in the new system.

One final feature of the system under development merits mention: All decisions of the Hospital Reimbursement Review Board are subject to appeal. All meetings of the board have been and will continue to be open to interested parties.

Historically, Illinois has reimbursed hospitals for all allowable costs incurred. This system of retrospective reimbursement provides no incentives for cost containment, nor any guarantee that more money buys better services.

The reimbursement system currently being developed is intended to make Illinois a conscientious, prudent buyer in this marketplace.

Senator TALMADGE. Mr. Miller, is there a fiscal crisis in the State of Illinois?

Mr. MILLER. The State of Illinois does not have a surplus of revenues, Mr. Chairman.

Senator TALMADGE. What is your answer?

Mr. MILLER. It is not blessed at the present time with a surplus of revenues. I am not sure I would characterize the present situation as a crisis.

Senator TALMADGE. As you know, this subcommittee has reviewed the medicaid problems in Illinois. We share your concern over the need to get Illinois medicaid costs under control. But aren't you concerned that your across-the-board limits on hospital costs will penalize the efficient institutions as well as the inefficient institutions?

Mr. MILLER. Mr. Chairman, we have not yet limited hospital costs. We would like to move to a prospective system. To date, we have been enjoined from even implementing an interim system.

Senator TALMADGE. If you are not limited, why is the mayor so upset?

Mr. MILLER. Mr. Chairman, what we proposed to do was implement new interim rates. We have voluntarily said we have not implemented those for fear of being without compliance. While I would not presume to speak for the mayor, the fact that we have not adjusted interim rates since October is causing problems for hospitals in Illinois.

Senator TALMADGE. What are your total estimated medicaid hospital costs in 1976?

Mr. MILLER. I have an estimate for fiscal year 1976 which was in my remarks, $308 million.

Senator TALMADGE. I didn't get the answer.

Mr. MILLER. $308 million for fiscal year 1976, the current fiscal year.

Senator TALMADGE. If Illinois were required to use the medicare formula and frequency of payment, how much more money would be currently required?

Mr. MILLER. That is calculated, based on the present medicare reimbursement requirements.

Senator TALMADGE. Hospitals claim that they are $80 million short, is that right?

Mr. MILLER. This morning is the first time I have heard that number. I can't relate to it, Mr. Chairman.

Senator TALMADGE. Now, you described your present payments as only interim.

How much additional money do you estimate will be due hospitals in final settlement for the year?

Mr. MILLER. We estimate we will pay hospitals $26 million in reconciliations this year.

Senator TALMADGE. Pay them how much?

Mr. MILLER. $26 million for the fiscal year that ends at the end of this month.

Senator TALMADGE. That is over and above the interim payments?

Mr. MILLER. Yes.

Senator TALMADGE. Has Illinois budgeted and appropriated that additional amount of money?

Mr. MILLER. We have appropriated for next year, we believe, sufficient sums to reimburse hospitals under the present methodology.

Senator TALMADGE. You didn't get into the area of the bill that is before us, so your testimony, I think, sheds some light on some of the problems that this committee faces.

Are you in favor of repealing section 111 of this law?

Mr. MILLER. If I may, I would like to defer to Mr. Grumley, of our Attorney General's office.

Mr. GRUMLEY. I certainly think that the State of Illinois and the Illinois Department of Public Aid are in favor of the repealer. From an attorney's standpoint, we certainly agree with the comments of the distinguished Attorney General from the State of Nevada. Likewise, Illinois has joined suit against HEW.

Senator TALMADGE. You also are opposed to the 10 percent penalty of medicaid payments?

Mr. GRUMLEY. Most vehemently, Mr. Chairman.

Senator TALMADGE. Could you comment on Mr. Levi's criticism of due process in the State of Illinois?

Mr. GRUMLEY. Your Honor, the Illinois legislature, in its wisdom, has created the Illinois Court of Claims. I am not advised that any clever Illinois attorney general has so characterized it or that it would set up any impediment to an adjudication of that claim in our State court of claims system, which is a legislative court.

So, I disagree with Mr. Levi's comments and I don't think we have had an opportunity to see that that would happen because, to my knowledge, few, if any, of the hospitals have pursued their remedies in the court of claims.

Senator TALMADGE. Do you think there is a reasonable alternative or reasonable remedy that the States could provide without waiving their constitutional rights?

Mr. GRUMLEY. I think it should be left to the several States, but I think there is a remedy in Illinois through our court of claims. Other States have administrative processes which afforded the same type of remedy.

Senator TALMADGE. Do you have any suggestions as to an alternative method? If you have, I would appreciate your drafting it and sending it to our staff.

Mr. GRUMLEY. I certainly will.

Senator TALMADGE. Thank you, very much.

Gentlemen, I appreciate your contribution and the hearing will stand in recess, subject to the call of the Chair.

[Whereupon, the hearing adjourned at 11:05 a.m.]

APPENDIX A

State Compliance With Federal Medicaid Requirements

PREPARED BY THE STAFF OF THE COMMITTEE ON FINANCE

Contents

I. Alleged Noncompliance by Illinois with federally-required medicaid hospital payment rates

Under Medicaid, States are generally allowed to determine appropriate reimbursement rates for covered health care services. However, with respect to payment for hospital care, States are required under Section 232 of Public Law 92–603 to use either the Medicare reasonable cost payment system or an alternative system approved by the Secretary as: (a) resulting in payment of "reasonable costs", and (b) not resulting in payment greater than would otherwise be made under the Medicare reasonable costs formula.

Previous to enactment of Section 232, HEW had required States to use the Medicare formula in reimbursing hospitals under Medicaid. States contended that this procedure "locked them in". Section 232 was intended to give States greater discretion in developing reasonable cost formulas.

Illinois, like many other States, is under severe budgetary pressure with respect to their Medicaid program. The State froze their "interim" hospital reimbursement rates for 1976 at April, 1975 reimbursement levels. Illinois originally submitted this change in payment procedure as an alternative reimbursement plan. The Secretary of HEW said that he did not have enough information to find that the plan resulted in reasonable cost reimbursement. Therefore, in the absence of additional information, he was unable to approve the alternative reimbursement mechanism. The State, however, is now paying hospitals on this basis and, therefore, may be out of compliance although no formal compliance hearing has been held.

As we understand it, the State now contends that it has not asked for approval of their revised payment system as an alternative reimbursement mechanism, but that it is merely an interim payment mechanism which will, when final settlement is made, result in full reasonable cost reimbursement.

A number of large hospitals in Illinois contend that the reimbursement mechanism being used in Illinois does not pay reasonable costs as required by Medicaid, and that this failure to pay reasonable costs is resulting in extreme financial hardship for these large hospitals. They maintain that unless the Secretary enforces compliance with the Medicaid law by threatening to cut off or actually cutting off Medicaid funds to Illinois, their hardship will continue and intensify. Further, the hospitals contend that even use of this enforcement mechanism would not really solve the hospitals' problem: (a) because it involves a potentially lengthy hearing and appeals process, and (b) because, if a Medicaid cutoff is made, it results in the State having less money for hospital payment purposes. They believe that the only answer to their problem is to be allowed to sue the State in Federal court in order to recover any funds found owing and for a mandated "appropriate" reasonable costs reimbursement system.

Until recently, although providers could sue States to enjoin action, States were immune from suits which would require payment of funds unless a State waived its Constitutional immunity from such suits.

II. General Issues

The Federal/State matching programs have become in a sense the keystone of Federal/State relations. These matching programs exist in health, welfare, education, environment and many other areas. Basically, the Federal/State matching grants are authorized under legislation which grants Federal monies to the States subject to the States having acceptable programs which meet various Federal statutory and regulatory requirements. If these Federal require-

ments are not met, the States may be found out of compliance and, theoretically, Federal matching funds withheld.

Due to the fact that withholding of funds is a very serious action and often penalizes not the State but those citizens directly assisted by the program, this method of withholding funds to assure compliance has often been threatened but very rarely utilized. Because of the inability of the Federal Government to effectively utilize this sanction, the whole structure of the Federal/State matching approach actually depends on reasonable good will between both the State and the Federal Government. Instances where a State clearly is out of compliance with the Federal requirements, as is alleged by the hospitals in the Illinois situation, become difficult for the Federal Government to deal with appropriately since the sanction of cutting off Federal funds entirely is so often unjust and politically unrealistic.

Another complicating factor is that in many Federal/State matching programs a number of States, for a variety of reasons, may consistently border on noncompliance with some details of the law and regulations, and any compliance mechanism which was too automatic in its operation might penalize some States which the Congress and the Administration might really not intend to penalize.

An underlying question is whether Congress and the Administration are willing to require strict enforcement of statutory provisions which entail substantial increases in State expenditures. Where such action on the part of Congress and HEW is doubtful, the concern of hospitals and others for access to the courts is understandable. The issue then becomes whether Congress is willing, through statutory authorization, to let the courts order those increased expenditures by States for Medicaid.

III. Compliance process in the medicaid program

The Department of HEW has the responsibility for assuring that State Medicaid programs adhere to the requirements of Federal law and regulations. If a State fails to comply with these requirements, HEW is empowered to hold a conformity hearing. A finding of non-compliance may result in a discontinuance of all Federal Medicaid funds though this penalty has never been invoked. The Secretary may take such action if: (a) a State has submitted a plan for administering its Medicaid program which does not meet Federal requirements, or (b) when an approved State plan is not carried out. Between October 1, 1969 and September 30, 1974, HEW regional offices reported over 2,300 instances in which States were not in compliance with Federal Medicaid requirements.[1] However, since 1970 compliance hearings have been scheduled in only three States. One of these States—Montana—was determined to have made the necessary changes before the scheduled hearing date and the hearing was canceled. Hearings were held in the two other States—Connecticut and Missouri; however, in both instances the States were subsequently determined to have made the necessary corrections in the operation of their programs and no Federal funds were withheld.

The general mechanism for assuring compliance in State Medicaid programs has proven cumbersome, time-consuming and often ineffective. Principal responsibility for identifying issues of non-compliance rests with HEW regional offices. While a number of cases have been identified, inadequate staff and unclear direction from the Central office have hampered their ability to adequately monitor all facets of the program requiring attention and to assure timely correction of deficiencies. While most of the instances actually identified as being out of compliance are subsequently corrected, the elapsed time is, in most cases, considerable. Additional problems are attributable to States' view of the penalty for non-compliance. It is generally assumed that the penalty, i.e., a total cutoff of Federal matching funds, is unlikely to be invoked because of the impact such a cutoff could have in the availability of health services for the poor. As a result, this penalty fails to serve as an adequate incentive for effective and efficient program operation.

Concern with the ineffectiveness of the existing compliance mechanism led the Congress to include provisions in the "Social Security Amendments of 1972" (P.L. 92–603) which provided specified penalties for failure to meet Medicaid requirements in targeted areas such as family planning and early screening.

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[1] U.S. General Accounting Office. Improvements needed in Medicaid Management including investigations of suspected fraud and abuse. Report to the Subcommittee on Health, Committee on Finance, U.S. Senate. Report No. MWD–75–74, Apr. 14, 1975.

These fiscal sanctions were sufficiently large to be noticeable but not so large that they would not be imposed. The Congress intended that the threat of a reduction in funds would elicit timely corrective action. The experience to date, however, has been mixed. Some improvements in performance have been noted. However, HEW has failed to effectively monitor State actions or apply the penalties in a timely fashion.

Another area receiving Congressional attention in the 1972 amendments was that of utilization control of services. Section 207 of that Act provides that, beginning July 1, 1973, States are subject to a one-third reduction in Federal matching payments for institutional care after 60 days in a hospital, skilled nursing facility or intermediate care facility and after 90 days in a mental hospital unless the State makes a showing satisfactory to the Secretary that it has an adequate program of control over the utilization of such services. The law specifies what must be included in an adequate demonstration by the State As part of his validation procedures, the Secretary is required to conduct sample onsite surveys of participating institutions. The burden of proof is on the States without which funds are to be automatically reduced. Despite the clear legislative mandate and the identification of a substantial number of States which have been out of compliance, HEW has failed to impose any reduction to date.

IV. Legislative Situation

Some months back Senator Taft had introduced an amendment which would have required States to waive their immunity from suits as a condition of participating under the welfare and Medicaid programs. His amendment was apparently introduced in reaction to a situation where the Supreme Court had found that a welfare recipient had been denied funds due him because of delays in the claims process. However, despite the verdict, the welfare recipient was unable to recover the funds owed him because States are immune under the Constitution to suits for damages.

When the Illinois hospital reimbursement situation arose, those representing the affected hospitals in Illinois believed that the Taft amendment might deal with their problem. A minor Social Security bill had been passed by the Senate and returned to the House last December. In lieu of a Conference, the House decided to accept certain amendments, rejects others, and add a new provision to a new bill which the Senate might then accept or reject as a package. The Senate approved the new bill (P.L. 94–182).

The new House provision, Section 111, was modeled after the Taft amendment but limited the States' consent to suit to instances involving provider groups contesting the reasonableness of the States' reimbursement system. States which did not consent to such suits were subject to a 10 percent reduction in Medicaid matching beginning January 1, 1976.

Soon after enactment, Governors began to call for repeal of this provision on the ground that States were being asked to waive one of their basic Constitutional rights—immunity to suit—without consent. Further, it required them to waive their immunity to suit on all questions, relating to the payment of the reasonable cost of inpatient hospital services; it is not limited to those situations where an alternate reimbursement system from that used by Medicare has been adopted. HEW, the Governors and Attorneys General of the States are all concerned that the result will be an unreasonable burden of suits which will be costly in terms of time and legal manpower, and which will make efficient program administration virtually impossible. In addition, because the reduction in matching penalty went into effect immediately, many States were unable to change their State plans rapidly enough to avoid being out-of-compliance for some period, since in some States, plan amendments required legislative action. Recent figures indicate that 13 States have refused to amend their plans and some 15 States have considered or have taken court action challenging the Constitutionality of the provision.

Last week the House sent to the Senate H.R. 12961 (referred to the Committee on Finance) which would repeal Section 111. Senators Taft, Percey and Stevenson have indicated their opposition to repeal of this section without an alternative remedy.

APPENDIX B

Repeal of Consent to Suits Respecting Hospital Provider Cost Under Medicaid

APPENDIX B

94TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 94–1122

REPEAL OF CONSENT TO SUITS RESPECTING HOSPITAL PROVIDER COST UNDER MEDICAID

MAY 11, 1976.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

including cost estimate of the
Congressional Budget Office

[To accompany H.R. 12961]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 12961) to amend the Social Security Act to repeal the requirement that a State's plan for medical assistance under title XIX of such act include a provision giving consent of the State to certain suits brought with respect to payment for inpatient hospital services, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

I. SUMMARY

The amendment repeals two provisions of current Medicaid law which:

(1) require that a State include in its State plan for medical assistance a provision granting the State's consent to suit in the Federal courts by or on behalf of providers of service on questions relating to the payment of reasonable cost for inpatient hospital services; and

(2) provide for a reduction of 10 percent of the amount of Federal Medicaid matching funds otherwise payable under title XIX of the Social Security Act to the State for expenditures in each quarter for which the State fails to include such provision in its State plan.

II. Background

The Subcommittee on Health and the Environment reported the bill to full Committee on Interstate and Foreign Commerce by unanimous voice vote on April 29. The full Committee considered the bill on May 5, and reported it by unanimous voice vote.

There has been no Senate consideration of similar legislation to date.

III. Cost of Legislation

The legislation has no estimable cost impact, although without it:

(a) States have alleged they would be subject to numerous suits in the Federal Courts, which would be costly in terms of the time and legal effort they require, and

(b) States who are so strongly opposed to consenting to suit that they refuse to amend their State medical assistance plans as required would suffer a reduction of 10 percent of the Federal matching funds provided under title XIX; thus to the extent the penalty was applied, Federal expenditures would be reduced.

The cost report prepared by the Congressional Budget Office follows:

Congressional Budget Office

cost estimate

1. Bill number: H.R. 12961.
2. Bill title and purpose: To repeal an existing provision under Title XIX of the Social Security Act which requires that a State waive immunity from litigation with respect to suits concerning payments for in-patient services.
3. Cost estimate: No budgetary impact.
4. Basis for estimate: Under existing law, a State could be fined by the Department of Health, Education, and Welfare for refusing to waive immunity. However, in the current services projections for Medicaid, it was assumed that States would have remained in compliance with the statute and thus not have lost those Federal payments. Thus, repealing this provision would not have any impact on current services projections.
5. Estimate comparison: Not Applicable.
6. Previous CBO estimate: Not Applicable.
7. Estimate prepared by: Jeffrey C. Merrill (225–4972)
8. Estimate approved by:

R. Scheppach,
(For James L. Blum, *Assistant Director for Budget Analysis*).

IV. History and Need for Legislation

The Medicaid program, established under title XIX of the Social Security Act, is a program of medical assistance for certain low-income individuals and families. Medicaid is financed jointly with State and Federal funds, with the Federal contribution to the cost of the program ranging from 50 to 83 percent. It is administered by each State. within broad Federal requirements and guidelines.

Title XIX of the Social Security Act requires that certain basic services must be offered in any State Medicaid program: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, skilled nursing facility services for individuals 21 and older, home health care services, physicians services, family planning services, and early and periodic screening, diagnosis and treatment services for individuals under 21. In addition States may provide a number of other services if they elect to do so, including drugs, eyeglasses, private duty nursing, intermediate care facility services, inpatient psychiatric care for the aged and persons under 21, physical therapy, and dental care. States determine the scope of services offered (they may limit the days of hospital care or number of physicians' visits covered, for example). They also in general determine the reimbursement rate for services, except for hospital care where they are required to follow the Medicare reasonable cost payment system unless they have approval from the Secretary of Health, Education, and Welfare to use an alternate payment system for hospital care.

The Department of Health, Education, and Welfare is responsible for assuring that States follow the requirements of the Federal law in their Medicaid program. If a State fails to comply with Federal requirements, the Department is empowered to hold a conformity hearing on the matter, and on a finding of noncompliance, to cut off all Federal Medicaid funds. This mechanism has proved to be unwieldly and time-consuming and has, in fact, only been undertaken once by HEW.

Public Law 94–182, signed December 31, 1975, added a provision to title XIX, which was intended to help with this problem. It required that States amend their medical assistance plans to include therein consent by the State to be sued in the Federal courts by or on behalf of providers of service on questions relating to the payment of reasonable cost for inpatient hospital services. The new provision follows:

CONSENT BY STATES TO CERTAIN SUITS

SEC. 111. (a) Section 1902 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(g) Notwithstanding any other provision of this title, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1861(u)) with respect to the application of subsection (a)(13)(D) to services furnished under such plan after June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th amendment to the Constitution or otherwise."

(b) Section 1903 of such Act is amended by adding at the end thereof the following new subsection:

"(l) Notwithstanding any other provision of this section, the amount payable to any State under this section with respect to any quarter beginning after December 31, 1975, shall be reduced by 10 per centum of the amount determined

with respect to such quarter under the preceding provisions of this section if such State is found by the Secretary not to be in compliance with section 1902(g)."

(c) The amendments made by this section shall (except as otherwise provided therein) become effective January 1, 1976.

The problem which the provision requiring States to consent to suit was designed to address related to actual or potential action by several States to freeze payment levels to hospitals or otherwise change their reimbursement system without receiving HEW approval for the variation from the Medicare method of paying for hospital care. Specifically, in Illinois, for example, the State had frozen the rate of interim payments to hospitals, without receiving approval from HEW for this change in procedure. The providers feared State-devised changes in hospital reimbursement would result in a loss of funds, or delay in receipt of payments. The providers feared that HEW would be slow to determine if State action was legal, and to bring a conformity hearing to cut off Federal funds if they did find the State out of compliance. Although the providers could sue the State to enjoin action States were immune from suits which would require payment of funds unless the State waived its immunity from such actions. The provision requiring States to consent to be sued in the Federal courts on issues relating to the payment of reasonable cost of hospital care effectively removed that immunity.

The provision itself, however, has become the cause of serious concern. First, in an effort to deal with a particular situation which had arisen in one or two States, a provision was adopted which now requires all States to waive one of their basic rights—immunity to suit. Further, it required them to waive their immunity to suit on all questions relating to the payment of the reasonable cost of inpatient hospital services; it is not limited to those situations where an alternate reimbursement system from that used by Medicare has been adopted. The Department of Health, Education, and Welfare, the Governors and Attorneys General of the States are all concerned that the result will be an unreasonable burden of suits which will be costly in terms of time and legal manpower, and which will make efficient program administration virtually impossible. Appendix I contains communications from the National Association of Attorneys General and the National Governors' Conference expressing their grave concern.

Secondly, the provision added by Public Law 94–182, also provides that any State which fails to change its State medical assistance plan to consent to suits by providers concerning payment of reasonable cost is subject to a penalty of a reduction of 10 percent in the amount of the Federal share of their Medicaid funds. This sizeable penalty went into effect almost immediately upon enactment of the legislation; the bill became law on December 31, 1975, and States had to change their plans before March 31, 1976. This rapid change in plans has been impossible for many States to affect; some even require a meeting of the State legislature to change the State plan.

Further, several States have refused to make the change in State plan because of their strong concern about the inadvisability of waiving their immunity. Many States are thus now subject to the penalty, in amounts which could total over $40 million in the first quarter. This substantial penalty bears little relation to any substantive question

relative to these States' administration of the Medicaid program. (Appendix II indicates the status of the various States according to information supplied by HEW.)

Finally, serious questions have been raised concerning the constitutionality of the provision. At least 12 States have instituted suits challenging it.

V. Committee Findings

The Committee finds that the pressing problems resulting from the requirement that States consent to suit make repeal of the requirement necessary, and the potential imposition of the penalty involving millions of dollars make timely action imperative. The Committee recommends that H.R. 12961 be adopted.

The Committee notes, however, that the problem which gave rise to the original consent-to-suit provision is of concern. In addition there are others—recipients of the program as well as other providers—who may reasonably expect a more satisfactory way to assure that States administer their Medicaid programs in compliance with the requirements of Federal law. The Committee has requested the Department of Health, Education, and Welfare to provide the Congress with recommendations for alternate ways to respond to these concerns. HEW has responsibility to assure that States operate in compliance with the requirements of the Federal law. If the tools available to it currently are not sufficient to accomplish this, the Committee expects the Department of Health, Education, and Welfare to request the changes in law that are needed. Nonetheless, the Committee is convinced that the urgent nature of the problems occasioned by the provisions of sec. 111 of Public Law 94–182 require immediate action to remove it from the law.

VI. Inflation Impact Statement

The legislation has no inflationary impact because it has no budgetary impact (see Cost of Legislation).

VII. Oversight Findings

No formal oversight findings were part of the Committee consideration of the legislation. The Committee acted rapidly to remove the requirement because of the emergency nature of the problems raised by the original provision.

No findings on the subject have been received from the Committee on Government Operations or this Committee's Subcommittee on Oversight and Investigation.

VIII. Section-by-Section Analysis

Section 1 of the bill repeals the section of title XIX which requires States to include in the State plan for medical assistance a consent by the State to suit in the Federal courts by or on behalf of a provider of services concerning the payment of reasonable cost of inpatient hospital services, and repeals the section of title XIX which provides for a reduction of 10 percent in the Federal matching funds otherwise payable to a State for medical assistance for each quarter in which the State

has failed to include a consent to suit in the State medical assistance plan.

Section 2 of the bill makes the repeal effective retroactively to January 1, 1976.

IX. Agency Reports

The favorable report of the Department of Health, Education, and Welfare on H.R. 12961 is as follows:

Department of Health, Education, and Welfare,
May 10, 1976.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your request for reports on H.R. 12915 and H.R. 12961, similar bills to amend title XIX of the Social Security Act to repeal the requirement that a State's medicaid plan include the State's consent to suit in Federal court by providers of inpatient hospital services.

In summary, although we believe that hospital providers should have some forum in which to arbitrate their differences with the States on reimbursement issues, we nevertheless are of the view that the consent to suit requirement is ill-considered and should be repealed.

In addition to amending section 1902(g) of the Social Security Act to require States participating in the medicaid program to waive their Eleventh Amendment immunity to suits brought against them by providers of inpatient hospital services, Public Law 94–182 also amended section 1903(e) of the Act to reduce by 10 percent, beginning with the first quarter of 1976, amounts otherwise payable by the Secretary under the medicaid program to a State that has not compiled with section 1902(g).

These provisions were the result of last-minute floor amendments to the bill. Had the responsible congressional committees been given the opportunity to consider and hold hearings on the amendments it would have become apparent that prompt compliance was impossible for a number of States.

In some cases, State constitutions must be amended and the legislatures are not in session. In other cases State legislatures were not in session for a sufficient period to pass the necessary implementing laws by March 31, 1976, the date set for compliance.

Moreover, inasmuch as the amendments seek to remedy a problem that relates only to medicaid expenditures for inpatient hospital services, their imposition of a penalty on a noncomplying State of 10 percent of its total medicaid funds seems harsh and unreasonable.

Under present law medicaid providers of inpatient hospital services are required to be compensated for what are known as their "reasonable costs." This rule has subjected the States and the Federal Government to substantial and rapidly escalating medicaid expenditures: expenditures that are out of proportion, in our judgment, to the value of the services provided. For this reason the President, in his February 9 Message to the Congress, recommended limiting increases in medicare payment rates in 1977 and 1978 (rates that control, also, medicaid reimbursement) to 7 percent a day for hospitals.

The inflation of health costs has created a near crisis condition in the budgets of some States. To meet this condition several States have imposed a freeze on their hospital reimbursement rates under medicaid. This freeze raises a substantial question with respect to the compliance of those States with title XIX of the Social Security Act and we have undertaken discussions with those States to resolve the matter.

From the standpoint of the hospital providers, however, the position of those States may create temporary cash flow problems for which the provider has no adequate remedy. We understand that State court relief is unavailable to a provider in those States whose courts deem the Federal Government (which is not amenable to suit in State court) to be a necessary party to any action. Relief to the provider in Federal court is also unavailable because of the Eleventh Amendment. Finally, there appear to be almost no States that have established administrative procedures in which providers may contest State reimbursement policy.

In supporting repeal of the amendment we therefore wish to underscore our serious concern with the problem that the amendment seeks to alleviate. Because of this situation the Department transmitted to the States on May 3, 1976, an instruction relating to State use of alternative methods of reimbursement for inpatient hospital services permitted by Department regulations (45 CFR 250.30(a)(2)(ii)). In substance, the Department proposes to approve alternative reimbursement methods only in the case of States that establish an appeals system under which hospitals may present data opposing the rates proposed.

In addition, providers can continue, of course, to institute suit for injunctive relief in State or Federal courts, as necessary. We would also point out that the enactment of the Administration's proposed Federal Assistance for Health Care Act, by removing the Federal involvement in establishing reimbursement rates, would doubtless remove also any basis for State courts to dismiss suits by providers against the State in State court on the ground that the Federal Government is a necessary party.

For all the foregoing reasons, we urge the enactment of either H.R. 12915 or H.R. 12961.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's objectives.

Sincerely,

(S) Marjorie Lynch,
Under Secretary.

X. Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of Rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) * * *

* * * * * * *

[(g) Notwithstanding any other provision of this title, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1861(u)) with respect to the application of subsection (a)(13)(D) to services furnished under such plan after June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th amendment to the Constitution or otherwise.]

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

[(1) Notwithstanding any other provision of this section, the amount payable to any State under this section with respect to any quarter beginning after December 31, 1975, shall be reduced by 10 per centum of the amount determined with respect to such quarter under the preceding provisions of this section if such State is found by the Secretary not to be in compliance with section 1902(g).]

* * * * * * *

APPENDIX I

STATE OF IDAHO,
OFFICE OF THE GOVERNOR,
Boise, April 28, 1976.

Hon. PAUL ROGERS,
Chairman, House Commerce Subcommittee on Health,
Rayburn House Office Building,
Washington, D.C.:

The nation's Governors recognize and appreciate your leadership in working to repeal Section 111 of P.L. 94–182. We are unanimous in support of H.R. 12961 and respectfully counsel prompt enactment by Congress.

(S) CECIL D. ANDRUS,
Chairman, Human Resources Committee,
National Governors' Conference.

THE NATIONAL ASSOCIATION OF ATTORNEYS GENERAL,
April 15, 1976.

Hon. FORREST D. MATTHEWS,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR MR. SECRETARY: At its April 12, 1976, meeting in Chicago, Illinois, the Executive Committee of the National Association of Attorneys General expressed deep concern regarding recent amendments to the Social Security Act which would require each State to waive its immunity to suit under the Eleventh Amendment. Specifically, the Committee is concerned with Section 111 of P.L. 94–182 which provides the Secretary of the Department of Health, Education and Welfare with the authority to withhold 10 percent of total federal financial participation for medicaid funds from States failing to execute the waiver. The Executive Committee adopted the following resolution for your consideration and action.

Be it resolved by the Executive Committee of the National Association of Attorneys General that the Secretary of the Department of Health, Education and Welfare be requested, in the strongest possible terms, to urge Congress to repeal Section 111 of P.L. 94–182 as being an improper intrusion into the constitutional and appropriate authority of the States.

We appreciate the opportunity to bring this most important matter to your attention and hope that you will support the repeal of this Section by Congress. I look forward to hearing your reaction to this recommendation.

Sincerely,

A. F. SUMMER,
Attorney General of Mississippi, President.

NATIONAL GOVERNORS' CONFERENCE,
Washington, D.C., April 19, 1976.

Hon. PAUL ROGERS,
Chairman, House Commerce Subcommittee on Health, Rayburn House Office Building, Washington, D.C.

DEAR MR. ROGERS: I wish to encourage your efforts to repeal Section 111 of Public Law 94–182 which would require that states waive any immunity from suit by providers of inpatient hospital services. That law also includes a provision that failure to agree to this waiver will result in a mandatory ten percent reduction in federal financial participation in a state's Medicaid program.

I have received communications from other Governors expressing their concern in regard to this law, and, as you are aware, many other states are opposed to the adverse impact of Public Law 94–182, Section 111.

The Department of Health, Education and Welfare required that the waiver be signed by the states by March 31, 1976. The State of Iowa did not sign that waiver and informed the Kansas City Regional Office that the state was joining other states in seeking repeal of this legislation. Obviously, we don't relish being in non-compliance, but

we believe this law is in violation of the 11th Amendment to the United States Constitution and an unjustifiable abrogation of the sovereignty of our states. Also, such an imposed penalty of 10 percent would deprive the underprivileged citizens of our states of the care and treatment that they need and to which they are entitled.

I have written to our Congressional delegation requesting that they exert all possible effort to secure repeal of Section 111 of Public Law 92–182. If I may be of assistance to you in this matter, please contact me.

Best regards.

Sincerely,

ROBERT D. RAY,
Chairman, National Governors' Conference.

APPENDIX II

STATUS OF STATE COMPLIANCE WITH CONSENT-TO-SUIT REQUIREMENT

	State has amended plan to consent to suit	State intends to amend plan to consent to suit	State refuses to consent to suit	Status unknown	Court action possible	Estimate of 10 percent penalty [1]
Total	34	3	13	3	15	$44, 545, 304
Region I	4		2		2	1, 014, 056
Connecticut	X				X	
Maine	X					
Massachusetts	X				X	
New Hampshire			X			441, 292
Rhode Island	X					
Vermont			X			572, 764
Region II	4				2	
New Jersey	X				X	
New York	X				X	
Puerto Rico	X					
Virgin Islands	X					
Region III	4		2		2	11, 972, 083
Delaware	X					
District of Columbia	X					
Maryland			X		X	2, 925, 965
Pennsylvania			X		X	9, 046, 118
Virginia	X					
West Virginia	X					
Region IV	2	1	4	1	4	16, 305, 046
Alabama	X					
Florida	X				X	
Georgia				X		4, 776, 449
Kentucky			X		X	2, 594, 999
Mississippi			X		X	2, 256, 576
North Carolina			X			3, 449, 378
South Carolina		X				
Tennessee			X		X	3, 227, 644
Region V	5		1		1	10, 033, 961
Illinois			X		X	10, 033, 961
Indiana	X					
Michigan	X					
Minnesota	X					
Ohio	X					
Wisconsin	X					
Region VI	4	1				
Arkansas	X					
Louisiana	X					
New Mexico	X					
Oklahoma	X					
Texas		X				
Region VII	2		2		1	2, 830, 387
Iowa			X		X	1, 538, 396
Kansas			X			1, 291, 991
Missouri	X					
Nebraska	X					

See footnote at end of table, p. 11.

STATUS OF STATE COMPLIANCE WITH CONSENT-TO-SUIT REQUIREMENT—Continued

	State has amended plan to consent to suit	State intends to amend plan to consent to suit	State refuses to consent to suit	Status unknown	Court action possible	Estimate of 10 percent penalty [1]
Region VIII	5		1		1	$1, 564, 151
Colorado			X		X	1, 564, 151
Montana	X					
North Dakota	X					
South Dakota	X					
Utah	X					
Wyoming	X					
Region IX	1	1	1	1	2	298, 839
American Samoa	NA					
Arizona	NA					
California	X				X	
Guam				X		14, 571
Hawaii		X			X	
Nevada			X			284, 268
Trust Territory						
Region X	3			1		526, 781
Alaska	X					
Idaho				X		526, 781
Oregon	X					
Washington	X					

[1] Based on 1st quarter expenditures for fiscal year 1976; estimate is for 1 quarter only.

Source: HEW, April 1976.

APPENDIX C

Communications Received by the Committee Expressing an Interest in These Hearings

STATE OF LOUISIANA,
EXECUTIVE DEPARTMENT,
Baton Rouge, June 4, 1976.

Hon. RUSSELL B. LONG,
217 Richard Russell Building,
Washington, D.C.

DEAR SENATOR LONG: Reference is made to Section 111 of P.L. 94–182 and to the upcoming Senate Finance Committee hearings on H.R. 12961.

We have serious questions about the legality of Section 111 of P.L. 94–182. This statute which was passed by the Congress takes away states' immunity to suit, a right which has been guaranteed by the Eleventh Amendment to the United States Constitution. Section 111 of P.L. 94–182 requires states to waive this immunity and allows states to be sued in the Federal Courts.

Under this new legislation providers of Medicaid services furnished after June 30, 1975, can sue the state in the Federal Courts if the provider disputes the state's decision regarding payments under the Medicaid program. This provision is particularly important to providers who are reimbursed on the basis of reasonable cost. At this time hospitals are the major providers who are reimbursed on a cost basis which will significantly increase the impact of this legislation and the possibility of costly and time-consuming lawsuits.

The State of Louisiana submitted State Plan material permitting consent to suit to avoid being penalized 10 percent of the Federal Medicaid match beginning January 1, 1976. This was done under protest and coercion, however, in that the state was forced to give up a right guaranteed by the United States Constitution in order to receive full Federal matching in the Medicaid program. In April, in letters to Louisiana's Congressional delegation (copy enclosed) I urged the repeal of Section 111. The Louisiana Health and Human Resources Administration, the state agency responsible for administering the Medicaid program, has also urged the repeal of this portion of P.L. 94–182.

If it is felt that some additional provider appeal system is needed, I would urge your consideration of an approach different from that espoused by Section 111 of P.L. 94–182. As an alternative to the legislation requiring consent to suit, it is recommended that a provider dissatisfied with payment for Medicaid services go through administrative procedure whereby he appeals the amount of payment to the state agency administering the program. Such appeal hearings would be conducted by the appeals section of the state agency. If the result of such a hearing is not satisfactory to the provider, he then has adequate remedy in Louisiana in that the state can be sued in the state court.

In conclusion, let me reemphasize your conviction that Section 111 of P.L. 94–182 should be repealed.

Sincerely,

EDWIN EDWARDS.

Enclosure.

STATE OF LOUISIANA,
EXECUTIVE DEPARTMENT,
Baton Rouge, April 19, 1976.

Hon. RUSSELL B. LONG,
217 Richard Russell Building,
Washington, D.C.

DEAR SENATOR LONG: On December 31, 1975, the President signed into law P.L. 94–182. One Section of this law poses a potentially serious problem for Louisiana, as well as all other states. This Section, Section 111, amends the Social Security Act to mandate that a state plan for Medicaid must include a consent by the state to the exercise of judicial power of the United States in any suit brought against the state on behalf of any provider of inpatient hospital services and a waiver by the state of any immunity from such a suit contained in the Eleventh Amendment of the Constitution. Effective January 1, 1976, any state which fails to include such a provision in its state plan is subject to a ten per cent reduction in federal financial participation for any quarter in which the requirement is not satisfied.

The Department of Health, Education, and Welfare subsequently required states to add this provision to their state plans or suffer the ten per cent penalty. Louisiana, under protest, made the required state plan change to avoid the penalty of some $14–15 million for the past quarter.

I seriously doubt that this amendment to the Social Security Act serves the public interest and I do not feel that it is appropriate for the federal government to require a state to waive its rights guaranteed under the Eleventh Amendment in order to receive full federal matching in the Medicaid Program.

Therefore, I request your assistance and urge you to work for the repeal of Section 111 of P.L. 94–182.

Sincerely,

EDWIN EDWARDS.

STATE OF NEW JERSEY,
DEPARTMENT OF LAW AND PUBLIC SAFETY,
Trenton, N.J., June 4, 1976.

Re Waiver of State sovereign immunity.

Hon. RUSSELL B. LONG,
Senate Finance Committee, 217 Russell Senate Office Building,
Washington, D.C.

DEAR SENATOR LONG: It is my understanding that on June 7, 1976, the Senate Finance Committee will be conducting oversight hearings concerning the waiver of state soverign immunity in context of the Social Security Act.

In light of this fact I would like to take this opportunity to express my views on the matter.

On December 31, 1975, Section 111 of P.L. 94–182 became law. This section had the effect of requiring each state to amend its State Plan for Medicaid so as to give its consent to suit in federal court by a single class of Medicaid providers, i.e. providers of inpatient hospital services. In giving this consent, each state was required to waive any immunity to suit by these providers "under the Eleventh Amendment or otherwise". Failure to agree to this consent is by this law penalized by forfeiture of 10% of each quarter's Medicaid funds. In New Jersey, such a penalty would amount to approximately $10 million a quarter or $40 million per year.

While we have facially complied with these onerous requirements to avoid forfeiture, by signing and returning the requested waiver, we have protested their imposition to the regional office of the Department of Health, Education, and Welfare and have permitted the Attorney General of Pennsylvania, acting on our behalf, to file a suit in the District Court for the District of Columbia, challenging the constitutionality of this legislation. This suit is currently in progress.

Not only do we have serious reservations about being forced to waive a basic right guaranteed by the United States Constitution to the states, but we think it particularly inappropriate to force this state into federal court when fair and adequate forums exist within New Jersey, both administratively and judicially, for the redress of any and all grievances felt by Medicaid providers. To have singled out a particular class of providers for this special treatment makes this situation even worse.

For these reasons, I wholeheartedly support the repeal of Section 111 of P.L. 94–182 by means of S. 3292, which I believe is designed to achieve this purpose.

Very truly yours,

WILLIAM F. HYLAND,
Attorney General.

BOARD OF COMMISSIONERS OF COOK COUNTY, ILL.,
Chicago, Ill., June 3, 1976.

Re Oversight Hearings on Section 111 of Public Law 94–182.

Hon. HERMAN E. TALMADGE,
Chairman of the Subcommittee on Health of the Senate Finance Committee.
(Attention of Mr. Michael Stern, Staff Director).

DEAR MR. CHAIRMAN: Cook County Hospital, which is located in the City of Chicago, is the only public hospital supported by property taxes within Cook County.

Approximately 40 percent of County Hospital's inpatients and approximately 36 percent of the outpatients and emergency patients are covered by the Medicaid program.

Refusals by the Illinois Department of Public Aid to adequately and promptly pay expenses for treatment of Medicaid patients at Cook County Hospital has created a disastrous financial problem.

Yesterday, I was informed by the Chairman of the Health and Hospitals Governing Commission that the State of Illinois owes Cook County Hospital $40.000,000.00 in unpaid bills. The hospital has received continued promises of payment; yet the balance due the hospital continues to rise. The excessive accounts receivable has exhausted the hospital's cash balance and necessitated interim borrowing adding to the cost of operations.

We would certainly urge the Committee to enact whatever legislation is necessary to assist all hospital facilities, both private and public, in expediting payment of all federally financed hospital expenses, either wholly or in part. Perhaps you might institute a technique whereby the federal government could pay the medical facilities directly.

On behalf of Cook County Hospital and the indigent citizens of Cook County, I wish to express appreciation to the Committee for any assistance rendered.

Sincerely,

GEORGE W. DUNNE, *President.*

OFFICE OF THE GOVERNOR,
Frankfort, Ky., June 3, 1976.

Hon. HERMAN E. TALMADGE,
Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate, Dirksen Office Building, Washington, D.C.

DEAR SENATOR TALMADGE: I regret that due to previous commitments, it is impossible for me to appear before the Subcommittee on Health of the Senate Finance Committee. However, I am submitting a statement for the record because I believe that Section 111 of Public Law 94–182, which requires states to waive their sovereign immunity to suit or lose ten percent of their Medicaid funds, should be repealed.

The essence of our comments is that we believe this type of legislation is destructive to effective administration of the Medicaid program which is vital to the health and well-being of the nation's citizens. The Commonwealth of Kentucky cannot effectively administer its programs if its policy decisions are to be reviewed by Federal Courts.

Kentucky's United States Senators and Representatives have sponsored and are supporting legislation to repeal Section 111 of Public Law 94–182. The Commonwealth of Kentucky is grateful for their efforts and we urge the Committee to approve this provision.

Sincerely,

JULIAN M. CARROLL.

STATEMENT OF GOV. JULIAN M. CARROLL, GOVERNOR OF THE COMMONWEALTH OF KENTUCKY

The Commonwealth of Kentucky maintains the position that the requirements contained in Section 111 of Public Law 94–182 for a state to operate and administer a Medicaid (Title XIX of the Social Security Act) program are: (1) an undue interference with the effective administration of the Medicaid program, (2) an unconstitutional exercise of the powers of the United States Government, (3) an unnecessary and unwarranted requirement to provide efficient and fair administration, and (4) a penalty against the indigent and elderly when a state refuses to give up rights guaranteed it by the United States Constitution.

Kentucky began its participation in the Medicaid program in 1966. During the past ten years this program has proven vital to the effort of providing adequate health care to citizens unable to bear the high costs for medical services. Our best estimates are that the 10 percent penalty provision, contained in Section 111 of Public Law 94–182 will mean a loss of $10 to $12 million in Kentucky's Medicaid program in this calendar year alone. This means that more of our citizens will receive inadequate health care. The state does not have the available money to make up this loss of revenue. Additionally, the Kentucky General Assembly, which adjourned in March of 1976, appropriated available state funds for the 1976–78 biennium.

The Commonwealth of Kentucky cannot comply with the provisions of Section 111 of Public Law 94–182. Kentucky's constitution provides that only the

General Assembly can consent to suits against the Commonwealth. Kentucky's General Assembly adjourned in March 1976 without consenting to suits as required under Section 111.

It is clear to us that Section 111 of Public Law 94–182 is an unconstitutional infringement upon the sovereign ability of the Government of Kentucky to administer its laws and programs without undue interference. The Eleventh Amendment to the United States Constitution has been consistently interpreted by the U.S. Supreme Court to forbid Federal Court Jurisdiction in suits by citizens of a state against the state.

Kentucky has never waived its rights under the Eleventh Amendment and has no intention of doing so now. We do not perceive any legitimate reason why consenting to Federal Court jurisdiction in this instance will benefit the administration of the Medicaid program, the recipients of services, or the inpatient hospital service providers.

Kentucky cannot consent to Federal court jurisdiction in this particular instance and maintain any semblance of a constitutionally formed government as provided for under the Constitution of the United States. It is inconsistent with the ideals of state sovereignty within the framework of a federal system of government.

Section 111 does not provide for Federal Court jurisdiction if a state acts arbitrarily or capriciously or denies rights to its citizens guaranteed by the U.S. Constitution of Federal law. What it does provide is Federal court jurisdiction in instances where private interests disagree with public policies as determined by constituted authority in accordance with Federal law and overall fiscal considerations.

Title XIX of the Social Security Act requires that Kentucky adopt a state plan for the administration of the Medicaid program which, among a myriad of other requirements, provides for the payment of "reasonable costs" to providers of inpatient hospital services. Kentucky's provision for the payment of reasonable costs has been accepted and approved by the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare.

Title XIX also provides that the costs paid in the Medicaid program shall not be greater than those costs reimbursed under the Title XVIII (Medicare) program. Kentucky has adopted Title XVIII standards for its payment of "reasonable costs" under the Medicaid program. The state of Kentucky now pays providers of inpatient hospital services the maximum allowed under Federal law. If Kentucky were to consent to a suit in Federal Court as required by Section 111, the possibility arises that any Federal judge could determine that payments made to providers of inpatient services do not reflect "reasonable costs". This possibility under P.L. 94–182 is simply untenable in that a Federal judge could order the state to make payments of money out of funds which have not been appropriated and probably are not available from state revenues.

If Kentucky were to obey a Federal Court order to adjust its payments it would then be in violation of Federal law which sets the maximum for payments of "reasonable costs". The state Medicaid plan would then be out of compliance with Federal regulations of the U.S. Department of Health, Education and Welfare. This implies the possible loss of all Federal medicaid funds. *Kentucky's dilemma is that if it does not comply with Section 111 of Public Law 94–182 it will lose 10 percent of Medicaid funds and if it does comply it faces the possible loss of all of its Medicaid funds.*

When Kentucky first began participation in the Medicaid program there was no requirement that the state waive its sovereign immunity in order to provide medical services to its citizens. During the past ten years the program has grown to the point that this year, Kentucky citizens will utilize $191 million of medical services for which the state will reimburse providers. Kentucky's indigent and elderly citizens are now dependent upon this program for adequate medical care. The penalty provision of Section 111 penalizes these dependent citizens. The essence of this particular provision is to penalize individual citizens for a state's refusal to allow Federal court review of its official policy, made in accordance with applicable laws of the United States, in regard to payments to private interest for their services.

STATEMENT OF STATE MEDICAID DIRECTOR'S COUNCIL, SUBMITTED BY GLENN JOHNSON, CHAIRMAN

REPEAL OF STATES' CONSENT TO SUIT UNDER PROPOSED SENATE BILL NO. 3292

BACKGROUND

A. Public Law 94–182

Under Section 111 of Public Law 94–182 effective January 1, 1976, States must consent to suit by inpatient hospital providers regarding payment of reasonable cost for inpatient hospital services furnished to Medicaid recipients after June 30, 1975, pursuant to Section 1902(a)(13)(D) of the Social Security Act. Also, States must waive their immunity from suit under the Eleventh Amendment to the Constitution or otherwise.

B. 10 percent penalty on Federal financial participation

Failure to consent to suit and file an amendment to a State's Plan for Medical Assistance by March 31, 1976, could result in a 10 percent penalty against a quarterly claim for Federal financial participation in expenditures for all services provided under an approved State Plan.

In Fiscal Year 1976–77, Medicaid Program Costs are expected to total $19 billion of which $9.5 billion is the Federal Share. The national financial reduction due to the 10 percent penalty on Federal Funds is estimated at $950 million in Fiscal Year 1976–77 if all States fail to comply. The reduction would result in curtailed services to recipients and not a penalty on State Program Administration.

C. State suits

States have entered suits in various Federal Courts to restrain the Secretary of Heath, Education, and Welfare from implementing the pertinent provisions of Public Law 94–182. A Temporary Restraining Order has been issued by the Federal Eastern Court of Kentucky to stay the implementation of the law. Other court decisions are pending on the issue.

D. Current law on inpatient hospital payments

Section 1902(a)(13)(D) of the Social Security Act provides "for payment of reasonable cost of inpatient hospital care as determined in accordance with methods and standards consistent with Section 1122 of the Social Security Act, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under Section 1861 (v) (Medicare) as the reasonable cost of such services for purposes of Title XVIII."

States have the option under this Section of the law to submit alternate methods for hospital payments under Medicaid. To date, HEW has approved alternate methods for hospital reimbursement for New York, Rhode Island, Colorado, and Wisconsin.

E. Medicaid State plan and Federal regulations

Basic Federal requirements for Medicaid State Plans and upper limits on payments by States for inpatient hospital services are contained in 45 Code of Federal Regulations 250.30(a)(2) and 250.30(b)(1). These regulations specify that States may follow the Medicare XVIII reimbursement methods or other plans approved by the Regional Commissioner, Social and Rehabilitation Service, Department of Health, Education, and Welfare in accordance with Federal criteria in Section 250.30(a)(2)(ii). Payments to hospitals are limited also to the lesser of reasonable cost of inpatient services or the customary charges to the general public for such services.

The Secretary of HEW can determine a State out-of-compliance for failure to implement an approved State Plan. Therefore, hospitals treated unfairly or arbitrarily by States can obtain administrative relief through HEW, Social and Rehabilitation Service, Regional or Central Offices.

F. Hospital reimbursement appeals

States provide for some type of appeal procedure or hearing for all providers and recipients regarding participation in Medicaid and payment for services. Hospitals do not need a Federal law, such as Public Law 94–182, to establish a legal channel to appeal administrative actions or decisions by a State agency.

G. Summary of hospital reimbursement

The State Plan and Federal regulations provide flexibility to States on methods of reimbursement to hospitals. Since 1966, hospitals have erroneously interpreted "reasonable cost reimbursement" under Title XVIII or Medicare principles as requiring States to pay full costs under Medicaid.

With limited State and Federal funds for Medicaid and in the absence of Federal payment standards, arbitrary reimbursement ceilings and caps must be implemented on institutional care expeditures to contain hospital costs within Federal and State appropriations. Adoption of such ceilings is consistent with the provision of other upper limits in CFR 250.30(b)(i).

Hospitals, nor any other medical provider, cannot be guaranteed full reimbursement through governmental programs although the goal is desirable and supported by the States. The levels of reimbursement must be established by mutual agreement between providers and State Agencies through processes within each State.

Recommendations

The State Medicaid Director's Council offers the following recommendations on the Consent to Suit issue:

1. There is no need for Public Law 94–182 which amends Title XIX of the Social Security Act to allow hospitals to sue States on reimbursement problems.
2. Senate Bill No. 3292 should be passed to repeal the provisions of Section 111 of Public Law 94–182.
3. The Department of Health, Education, and Welfare should amend 45 CFR 250.21 on "Agreements with Providers" to require as part of all Provider Agreements that an appeal procedure or hearing be available to all providers upon written request to the State Agency, regarding participation or reimbursement problems under Medicaid.
4. Dissatisfied providers should appeal administrative hearing decisions of State Agencies in State Courts or a State Board of Arbitration of Claims and not Federal Courts.
5. The Department of Health, Education, and Welfare should continue to furnish information on approved State Plans and Federal Medicaid laws and regulations to providers or their associations and monitor the implementation of approved State Plans. The Secretary of HEW can presently force States to comply with their approved Plans by withholding Federal funds which is sufficient leverage to obtain compliance.

SUMMARY

Public Law 94–182, Section 111, is special legislation affecting inpatient hospitals and excludes various other medical providers. The law is discriminatory and is not necessary to provide administrative or legal relief to dissatisfied providers under Medicaid.

The State Medicaid Director's Council supports the repeal of the provisions of Section 111 of Public Law 94–182 through the passage of Senate Bill No. 3292.

ILLINOIS HOSPITAL ASSOCIATION SUMMARY ANALYSIS

Attached is an analysis of Medicaid's payment freeze on seven institutions in Illinois. The impact of payments below current cost levels range from approximately Five Hundred Thousand Dollars to nearly Three Million Dollars.

These seven institutions were selected on the basis of availability of financial data and not on the basis of being the most impacted institutions within Illinois.

A partial listing of other institutions severely impacted is as follows:

Bethany Brethren-Garfield Community Hospital, Chicago, Ill.
Christian Welfare Hospital, East St. Louis, Ill.
Doctors Memorial Hospital, Carbondale, Ill.
Michael Reese Hospital and Medical Center, Chicago, Ill.

Padco Community Hospital, Cairo, Ill.
Provident Hospital, Chicago, Ill.
St. Mary's Hospital, East St. Louis, Ill.
University of Chicago Hospitals and Clinics, Chicago, Ill.
University of Illinois Hospital, Chicago, Ill.

ILLINOIS HOSPITAL ASSOCIATION

SUMMARY ANALYSIS, FISCAL IMPACT OF MEDICAID PAYMENT FREEZE

	Payment differential, current cost less medicaid's frozen rate [1]	Annual medicaid days	Annual underpayment due to State's freeze [2]	Medicaid date of last increase [3]	Medicare date of last increase [3]
Evanston Hospital	$72.55	6,597	$478,612	May 1, 1975	Mar. 8, 1976
Illinois Masonic Medical Center	19.83	30,794	610,645	Apr. 1, 1975	May 31, 1976
Mercy Hospital and Medical Center	22.86	40,373	922,927	Aug. 1, 1975	May 31, 1976
Mount Sinai Hospital Medical Center	33.21	47,180	1,566,848	Oct. 1, 1975	Feb. 23, 1976
Northwestern Memorial Hospital	42.06	19,397	815,838	Aug. 1, 1975	Apr. 18, 1976
Rehabilitation Institute of Chicago	62.85	9,925	623,786	Mar. 1, 1975	Aug. 18, 1975
Rush-Presbyterian-St. Lukes Medical Center	59.11	50,120	2,962,593	June 1, 1975	Mar. 31, 1976
Total cumulative underpayment			7,981,249		

[1] National average shows medicaid per diem cost ratio at 103 percent of average per diem cost all patients. The underpayment rate shown does not consider this trend.
[2] Underpayments shown are due exclusively to the State's arbitrary freeze on rates and does not reflect the slowdown in payments.
[3] Demonstrates major discrepancy between last update of medicaid payments (title 19) versus medicare (title 18).

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

On behalf of the American Hospital Association, representing almost 7,000 health care institutions (including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, and hospital schools of nursing), and over 23,000 personal members, I want to express our views and recommendations regarding Section 111 of Public Law 94–182. We thank you and your Committee for this opportunity for a full hearing on this very important matter.

Section 111 of Public Law 94–182 requires that state plans submitted pursuant to provisions of Title XIX of the Social Security Act must include consent by the state to suits by providers of inpatient hospital services challenging the reasonableness of reimbursement under the Medicaid program. Failure to comply with this waiver requirement subjects the state to a penalty of 10 percent of the federal matching funds for each quarter of noncompliance.

THE PROBLEMS

The problems which gave rise to enactment of Section 111 are of long standing. They derive from the federal-state nature of the Medicaid program. Cases have and will continue to arise in which some states take action to modify their Medicaid reimbursement plans in a manner that does not conform to federal law or take actions that are contrary to their own state plans.

As this Committee knows, Title XIX of the Social Security Act specifically requires participating states to "provide for payment of the reasonable cost of inpatient hospital services provided under the plan as determined in accordance with methods and standards, consistent with Section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan. . . ."

Despite these requirements, a number of states have proposed or taken action to limit reimbursement arbitrarily under the Medicaid program. They have sought to apply limitations that do not reflect the reasonable cost of providing services to Medicaid beneficiaries and, in fact, have proposed to pay unreasonable amounts below the cost of providing services. For example, the State of Illinois

froze hospital reimbursement rates at the level in effect in October 1975 without regard for the increase in costs that hospitals have experienced in rendering services to Medicaid patients. This arbitrary action has imposed serious financial difficulties on hospitals in Illinois.

Even in the face of this inappropriate action by the State of Illinois, the only recourse to judicial review and recovery of monetary damages is in the Illinois Court of Claims. This avenue of judicial consideration is inadequate because of the requirement that prior to determination by the Illinois Court of Claims all administrative and equitable remedies must be exhausted. Judicial review of these issues in Illinois is further complicated by the fact that the decisions of the Illinois Court of Claims are restricted by a one-year statute of limitations for claims under public aid. Timely judicial consideration of such serious reimbursement issues is essential to maintaining a hospital's ability to care for its patients.

Section 111 of Public Law 94–182 is intended to provide prompt judicial recourse in federal courts. Unfortunately, it relies for enforcement upon a penalty which would withhold 10 percent of the federal grant funds each quarter from states which do not comply with the requirements to permit suits by providers in federal court.

The lack of adequate and timely judicial recourse in Illinois and elsewhere is a serious inequity which must be addressed. On the other hand, the penalty of withholding federal funds included in Section 111 should be removed. Withholding such funds by the Department of HEW has only rarely occurred and has been difficult to accomplish administratively. Such action, if taken, further complicates the situation for hospitals and the patients they serve.

RECOMMENDATION

The American Hospital Association supports an amendment to Section 111 of Public Law 94–182 which would:

1. Require Section 111(a) to statutorily recognize that a state's participation in the Medicaid program shall be deemed to be a waiver of its immunity to suits by providers in federal court in any state which does not provide adequate and timely judicial recourse to providers. Such judicial recourse must ensure that providers receive reasonable and prompt payment for Medicaid services as defined by federal law and the regulations of the Secretary of the U.S. Department of Health, Education, and Welfare.
2. Delete the imposition of the penalty contained in (b) of Section 111 which would withhold 10 percent of the federal matching grant funds for any quarterly period of a state's noncompliance.

Mr. Chairman, we appreciate this opportunity to present our concerns and recommendations on this matter.

STATEMENT OF THE HOSPITAL ASSOCIATION OF PENNSYLVANIA ON PROPOSED REPEAL OF SECTION 111 OF PUBLIC LAW 94–182

The Hospital Association of Pennsylvania (HAP) and its over 300 member hospitals welcomed the inclusion last year of Section 111 of Public Law 94–182 as a means of seeking legal redress for inequities and unreasonableness associated with the administration of the Medical Assistance program in the Commonwealth of Pennsylvania. Our hospitals have, for years, been operating under a system which is frustrating and ineffective in dealing with the provision of medical care services to recipients of Medical Assistance in the Commonwealth. The situation has reached the point where a number of hospitals, primarily in urban areas, which provide the highest percentage of care under the Medical Assistance program are no longer able to financially tolerate the inequities and unreasonableness of the system.

The Association this year has committed itself to placing a high priority on the resolution of specific problem areas in the administration of the Medical Assistance program in Pennsylvania which must be corrected. We have had discussions with representatives of the U.S. Department of Health, Education and Welfare on how to approach the resolution of our problems. We have been advised that there are two avenues of final resolution: cancellation of the Medical Assistance contract between the hospital and the Commonwealth; or, actually refuse care to patients, which would result in the State's non-

compliance with its obligation to the Federal government. We have been advised that as long as citizens are receiving care, the State has fulfilled its responsibility to the Federal government. The latter action would put the burden for any challenge on the hospitals themselves. You can well understand the philosophical problems that are involved with a decision such as this by providers of health care services in the Commonwealth. We are, therefore, pursuing the former route and, to date, have received authorizations from over 170 hospitals in the Commonwealth to act as their negotiating agent in establishing a new contract for Medicaid with the Pennsylvania Department of Public Welfare. It is hoped that through this method we might be able to achieve some improvements in the system. This strategy was developed primarily because of the inability of Pennsylvania hospitals to seek legal redress for grieavnces. Providers of care in Pennsylvania, and elsewhere, vitally need a method of judicial recourse to achieve timely, effective and equitable resolutions of disputes associated with Medicaid administration.

In preparation for our negotiations with the Commonwealth and its Secretary of Public Welfare, we have identified major problem areas. Some of those areas will be cited here to illustrate the inequitable and unreasonable defects in the administration of the Medical Assistance program in Pennsylvania. They are as follows:

A. MEDICAL ASSISTANCE PROGRAM INPATIENT HOSPITAL CARE AGREEMENT

This is a basic contract which all hospitals participating in the Medical Assistance program in Pennsylvania must sign. The contract presents many problems to the hospital industry in Pennsylvania. The following section is cited as an example:

"SECTION A—HOSPITAL RESPONSIBILITIES

"*Point 6.*—Maintain effective agreements with extended care, sub-acute care, long-term care, intermediate care, and similar facilities for the prompt transfer and admission of patients who no longer need general hospital services but still require the above types of institutional care. Exceptions to this requirement may be made by the Department providing the Medical Assistance Program objectives are met.

"*Point* 7.—Plan in cooperation with the County Assistance Offices of the Department to assure the timely transfer to lesser levels of care or discharge of Medical Assistance patients no longer requiring inpatient hospital care."

Although the hospital industry can clearly document that these agreements are in effect, the Pennsylvania Department of Public Welfare continues to financially penalize hospitals who are unable to transfer patients to lower levels of care facilities because beds are not available. Although this is in no way the fault of the hospital, the hospital nevertheless is penalized by receiving no financial reimbursement. A suit brought by Temple University against the Department of Public Welfare (Commonwealth versus Temple University, Pennsylvania Commonwealth 343 A.2d (1975)) to determine the validity of the Department's policy was decided in favor of Temple in September, 1975; however, the Department has indicated it considers the decision to apply only to that specific case, and continues to penalize hospitals accordingly.

"*Point 15.*—Agrees to abide by the Department's Medical Assistance Regulations and all other applicable State and Federal Laws and regulations in existence at the effective date of the agreement and as they may be changed from time to time. Failure by the hospital to comply with law or regulations shall entitle the Department to terminate the contract forthwith. Any new or revised State and Federal regulations and laws adopted, which affect this agreement or the hospital's performance hereunder, constitutes an option on the part of the hospital to terminate this agreement within 30 days if such changes are not acceptable to the hospital."

This contract provision is unacceptable since it requires hospitals to accept future provisions which have not yet been established without any opportunity for review or due process.

B. ELIGIBILITY CERTIFICATION PROCESS

This process continues to be one of the most aggravating, costly and time-consuming problems that hospitals experience with the Department of Public

Welfare. It currently requires an average of 30 or more days in major cities like Philadelphia and Pittsburgh for the County Offices to supply eligibility information to hospitals. Since the average hospital stay is around nine days, the hospital admits, treats and discharges a patient long before the hospital finds out whether the patient is eligible. If the patient is ineligible, the hospital frequently is unable to collect the bill, and must recoup its losses by increasing charges to paying patients.

This problem has been carefully studied and documented by the Hospital Advisory Committee, and as a result of its recommendations, the Department adopted Memorandum No. 99 which requires all County Offices to determine eligibility within 21 days. Although this memorandum was issued on August 15, 1975, and has been received by all County Offices, it is not being implemented in most County Offices throughout the State. The problem is greatly magnified in cities where the number of applicants is high and where other priorities exist in the County Offices.

HAP officials have made visits to various County Offices and have concluded that drastic revisions are necessary in the administration of this program at the county level. There is no computerization; files are frequently lost, misplaced or not available; and identification cards with valid dates are frequently inactive or inaccurate. Many other examples of the inefficiency of the present system could be cited. In general, the current system for determining eligibility is atrocious. Recently, it has been reported that Pennsylvania will be denied some funds by the Federal government for poor administrative practices. It is generally acknowledged that a three percent error rate is acceptable in determining eligibility. Recently, Pennsylvania reduced its error rate in determining eligibility from 28 percent to 24 percent. The public has a right to better performance from the Department of Public Welfare.

C. REIMBURSEMENT FOR AMBULATORY SERVICES

In general, a state Medicaid plan must provide that payment for care or services is not in excess of the upper limit set by Federal regulation. The upper limits for payment for outpatient hospital services and physician services are "customary charges which are reasonable."

Most Pennsylvania hospitals have been reimbursed since January 1973, at the rate of $6 per outpatient visit. (Hospitals meeting certain criteria are authorized $9 payments.) Fees for ancillary services are both incomplete and considerably less than customary charges to other patients. For example, a study by the Pennsylvania Economy League found that 35 hospitals in the Philadelphia area experienced a $5.8 million loss on Medicaid outpatients alone in 1973. The study pointed out that reimbursement for Medical Assistance outpatient services was approximately one-third of the actual cost. The loss is even greater today.

Inadequate outpatient reimbursement undoubtedly has contributed to a lack of accessible ambulatory health care services, suboptimal services, some hospitalizations for procedures that could have been performed on an outpatient basis, and a deterioration of the financial situation of a number of urban hospitals faced with a high Medical Assistance case load.

A second major problem with reimbursement for ambulatory services is the Department's discriminatory practice of issuing fee schedules which differ according to where service is provided. One fee schedule applies to physicians' offices, another applies to hospital outpatient departments, and a third applies to hospital emergency departments. Current fee schedules encourage inappropriate utilization.

D. ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE

The Medical Assistance maximum income level in Pennsylvania has not changed since 1967. In the past nine years, we have experienced serious inflation and consequent increases in the Federal poverty level. In 1969, for example, the poverty level for a family of four was $3,600—or $400 less than the maximum income limit for Medical Assistance in Pennsylvania. By 1974, the poverty level had increased to $5,038—over a thousand dollars greater than the Medical Assistance maximum income limit, which is still $4,000. The effect is that greater numbers of persons are becoming ineligible for Medical Assistance, yet do not have the resources to pay for medical care. As suggested earlier, hospitals must increase charges to paying patients in order to recoup losses they experience through unpaid bills.

The General Accounting Office, in a report to Congress in 1975 on outpatient health care in the inner city, stated that:

"Outpatient care is the fastest growing service in the nation's health care system. Between 1962 and 1973, outpatient visits increased from 71 million to 164 million.

"Increasing numbers of people—particularly in the low-income bracket—are seeking health services from the outpatient care system. The Federal Government has encouraged the use of outpatient care as an alternative to more expensive inpatient care and as a means of providing comprehensive care.

"Many low income people who cannot afford to pay for all or part of their health care are not covered by Medicare or Medicaid. These people and the many Medicaid and Medicare eligibles seek outpatient care because of the shortage of physicians in the inner cities."

Later on in the report, funding of outpatient care is discussed. The report states: "Even though the medically indigent were the primary users of outpatient care (this group accounted for 48 percent of the outpatient visits), they contributed only 9 percent of the total funds."

The implication here is obvious—other patients are paying for these services through higher fees. The Pennsylvania Economy League's study of outpatient care in southeastern Pennsylvania showed that 56 percent of the outpatient losses were attributable to free care, charity discounts, bad debts, and contractual allowances.

The study noted: "That a substantial proportion of clinic and emergency patients not on Medicaid are from low income families just slightly above the Medicaid level."

The variance between income eligibility requirements and the poverty levels has created an undue hardship on providers of health care in Pennsylvania.

E. CURRENT FINANCE MECHANISM

The Medical Assistance program is the slowest third party payor in Pennsylvania, with an average processing time of four months—approximately twice that of Blue Cross, Medicare and commercial carriers. In a typical month, the Commonwealth of Pennsylvania is $13 million in arrears to hospitals in this Commonwealth. This figure, coupled with Federal matching funds, amounts to a total of $28 million that is due hospitals in a typical month in Pennsylvania for Medical Assistance care. The usual payment time to providers by the Commonwealth is 120 days. In a period of fiscal difficulties, the Commonwealth can slow the cycle down further to maintain its own cash flow and hospitals can do nothing but watch it happen. The process must be improved dramatically in order to meet the cash flow requirements of Pennsylvania hospitals. Under Medical Assistance, hospitals must wait until all documents are processed before payment can be made. The Medicare program, by contrast, has established a periodic interim payment system to assist hospitals in this regard.

F. AUDIT PROBLEMS

1. *Auditor General's disallowance of legitimate costs.*—The Auditor General of Pennsylvania, in cooperation with officials of the Department of Public Welfare, has continued to disallow certain appropriate costs which the hospital industry considers essential and reasonable. These costs include, but are not limited to, items such as: chaplaincy costs, relocation costs, recruitment costs, etc.—all of which are deemed appropriate under the Medicare program. A fundamental problem, therefore, is that the State uses standards which are different from other third party payors in determining appropriate and reasonable costs.

2. *Inadequate appeals process to resolve differences relative to the Auditor General's audit.*—At the present time, no methodology exists for fair handling of disagreements arising on reimbursement issues. An Appeals Board must be established to resolve differences of opinion in the administration of this program, including a provision for access to legal recourse or binding arbitration.

3. *Interim settlement on filed cost reports.*—Upon completion of a desk review, the hospital should receive an interim payment on its filed cost report prior to final audit. This practice is used by Medicare intermediaries and most Blue Cross plans to recognize the long time delay from the time of filing to the time of audit. This delay adversely affects the hospital's cash flow position; needlessly in-

creases the cost of health care; and in a period of inflation, forces substantial losses upon the hospital's purchasing power.

4. *Long delay for final settlement on filed cost reports.*—It is grossly unfair for providers of health care services to wait beyond a reasonable time for payment of funds for services rendered. Presently, most hospitals wait over a year from the date of filing.

SUMMARY

The Hospital Association of Pennsylvania has attempted in this statement to present some insight into the problems which providers in the Commonwealth are working with. The Association is fully aware of the reluctance of State governments throughout the country to support Section 111 of Public Law 94–182. In conclusion, we implore the Committee to recognize the necessity for provision of a method for judicial recourse for providers participating in the Medicaid program throughout the country. Section 111 or a similar alternative would provide such a method.

STATEMENT OF JULIAN LEVI

I

I am Julian Levi. I live in Chicago, Illinois. I am Professor of Urban Studies at the University of Chicago, Chairman of the Chicago Planning Commission and a Trustee and member of the Executive Committee of Michael Reese Hospital and Medical Center of Chicago. Attachment A describes the salient features of this institution.

May I begin by expressing our deep appreciation to Senators Long and Talmadge for their courtesy in arranging this hearing and to Senators Robert Byrd, Percy, Stevenson and Taft for their great assistance in these matters and to an extraordinarily able and committed staff not only in the offices of the Senators but your own Committee Staff, particularly Messrs. Michael Stern, Jay Constantine and Dr. James Mongan.

What is said here is completely documented. Since your time is limited, supporting material is assembled as an appendix.[1]

II

The only objective hospitals seek in these proceedings is to preserve a remedy that will enable them to seek reimbursement at law for care rendered and goods provided to eligible beneficiaries of the medicaid and welfare programs in accordance with the Social Security Act.

Accordingly, I wish to make it clear than the hospitals' objectives do not involve substantive issues of any kind regarding the amount or eligibility of any claim, nor do they support the withholding of Federal fund reimbursement from any State.

The issue before you can be put simply: What recourse is available at law to a provider when the state department that administers medicaid reimbursement wrongfully and illegally refuses to pay its just debt to the provider?

Section 111 was enacted to give providers a judicial remedy in just such a situation. H.R. 12961, if enacted into law, will destroy that remedy altogether. In the practical sense, it will leave providers defenseless and with no effective recourse at law whatsoever. Because the provider's accounts receivable will not be enforceable at law, they will not be bankable or acceptable collateral. The providers will then be unable to pay their bills.

III

In *Edelman* v. *Jordan* in 1974 (415 U.S. 651) (Attachment 2) the Supreme Court decided that the 11th Amendment of the U.S. Constitution bars a Federal Court awarding improperly denied welfare benefits where state welfare officials had promulgated and followed procedures in violation and contrary to the federal statutes and regulations. The state of Illinois, of course, has used Edelman as suggested (Attachment 3).

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[1] The appendix referred to was made a part of the official files of the committee.

Thereafter, the Senate Committee on Appropriations asked the Secretary of HEW to make a careful review of the matter and explore possible alternatives to this decision (Attachment 4).

HEW responded by writing to Chairman Warren Magnuson recommending that the provisions of the Social Security Act be amended to make consent to suit in the Federal Courts a condition of any state's participation in the Social Security program. (Attachment 4A)

Section 111 (Attachment 5) was enacted in accordance with this advice.

Even after the introduction of H.R. 12961, the House Committee on Interstate and Foreign Commerce as well as the Undersecretary of HEW recognizes that the problem of Edelman is of great concern. (Attachments 6, 7)

IV

HEW's involvement and knowledge of this matter is much deeper, however. On October 6, 1975, the Illinois Department of Public Aid told all hospital providers of Medicaid in Illinois that they must agree to an alternative reimbursement plan. This alternative plan provided for a freeze and rollback of rates, even though, contrary to law, it had not been approved by HEW (Attachment 8). On January 8, 1976, the regional office of HEW found the alternative reimbursement plan arbitrary and illegal. It disapproved the plan and directed Illinois to continue to reimburse providers under the earlier state plan (Attachment 9).

The State of Illinois then sought review of this decision by instituting suit in the Federal District court against the Regional Director and the Secretary of HEW (Attachment 10). On March 22, the Secretary of HEW, responding at the urging of the two Illinois Senators, wrote that "he could not comment on the details or merits of the proposal" even though the Regional Commissioner had refused to approve the alternative plan. (Attachment 10A)

On behalf of HEW, the United States District Attorney filed an answer in Federal Court again asserting the illagality of the state plan. But HEW took no action whatsoever to secure compliance, even though the state was then before the Federal Court. (Attachment 11) Subsequently, the state on its own motion dismissed its suit against HEW.

To this day, the Illinois Department of Public Aid continues to administer this federally assisted program to deliberate, open, and notorious defiance of law without any interference from HEW.

Since February 1970, this Committee has criticized the administration and supervision of the Medicaid program by HEW. The same criticism is repeated in a recent report of the Controller General of the United States. (MWD–75–74, April 14, 1975).

V

Despite explanation, HEW does not understand the lack of any legal remedy. Under Edelman, the Illinois Statutes, and decided cases:

1. Without federal legislation overruling Edelman, sole recourse must be had in the State courts.

2. Under Statute, monetary damages may be awarded only in the Illinois Court of Claims.

3. Determination in the Illinois Court of Claims is not available until all administrative, legal, and equitable remedies have been exhausted. Thus a claimant must proceed in Circuit Court under the Administrative Review Act; but in that proceeding, even if his appeal is sustained, monetary damages cannot be awarded.

4. Finally, the Illinois Court of Claims has a general 5-year statute of limitations *except as to claims under Public Aid where the statute is one year.*

Limitations of jurisdiction to a Court of Claims or a Special Commission are found in many states including New York, Pennsylvania, Ohio, Michigan, Georgia (Claims Advisory Board), and Tennessee. Special Provisions exist in New Jersey, North Carolina, Connecticut, Arizona, Virgina, and Wisconsin. Moreover, HEW has found that because of extraordinary increases in costs, many states are considering alternative methods of reimbursement, many of which will not meet the requirements of law. (Attachment 12.)

Moreover, any competent state Attorney General will be able to delay matters even further, as has been the case in Illinois, by recourse to the federal courts. Thereafter, the jurisdictional thicket in the state courts will begin.

VI

The decided cases without question hold that the federal government has the right to impose reasonable conditions on the states in their use of federal funds. This includes the right of Congress to render a state suable in federal court as a condition of state participation. (Attachment 13.)

The Supreme Court in Edelman accepted this doctrine without question. The issue was limited to whether the condition imposed by Congress could be implied or must be specifically stated. The majority (5–4) held the latter. Thus, as the Taft Amendment proposes, a clear statement by the Congress is all that is required. Hence, withholding is not required nor even the execution of any document. Participation alone under conditions established by the Congress suffices.

Since withholding of federal fund reimbursement is counterproductive, its repeal is supported.

VII

The core issue here is integrity. The Congress in enacting the Medicare and Medicaid Statutes in the name of the American people, intended to make health care available to all Americans without regard to income, to insure that the quality of health care would *not* be conditioned upon the poverty or wealth of the patient. The Congress sought to achieve equity—it did not intend that hospitals and medical centers be profiteers or victims or that the middle income patient be burdened with the cost of care of other patients.

Repeal of Section III without an adequate substitute will leave the rhetoric but not the reality of equity in place.

The issue is also one of cowardice. The bureaucracy of Illinois knows that its hospitals and medical centers are the proud inheritors of the generosity of past generations, and that these places will not easily close the door on any patient in distress. In effect, the state bureaucrats' implicit assumption is that the moral code of the hospital trustee is higher than his own.

For those returning to Springfield, and yes, Annapolis and even to Independence Avenue in this city I recommend Louis Adamic for their reflection:

"There is a certain blend of courage, integrity, character, and principle which has no satisfactory dictionary name but has been called different things at different times in different countries. One American name for it is 'guts'."

STATEMENT OF THE AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association (AHCA) is the oldest and largest representative of long-term care facilities in the United States. Substantially all of its more than seven thousand (7,000) member facilities participate in the Title XIX Medicaid program as providers of skilled nursing and/or intermediate care services.

We have reviewed the testimony of the witnesses who appeared on June 7, 1976 before your Subcommittee on Health. The testimony relates to the Subcommittee's consideration of (1) the availability and adequacy of administrative and judicial review procedures in situations where questions of state compliance with federal Medicaid requirements are raised, and (2) the imposition of sanctions on programs which fail to provide such procedures.

The Subcommittee's study of these problems is essential because it is considering a bill (H.R. 12961) which would repeal Section III of Public Law 94–182 (Sections 1902(g) and 1903(a)(1) of the Social Security Act, 42 U.S.C. §§ 1396a(g) and 1396b(a)(1)). These existing provisions require the states participating in Medicaid to waive their Eleventh Amendment immunity to suits in federal courts in cases involving disputes over reimbursement for inpatient hospital services. If a state refuses such consent, imposition of a penalty, amounting to ten percent (10 percent) of its federal matching funds, is authorized.

Inasmuch as these provisions were the result of last minute floor amendments, formulated wihout hearings, and relating only to providers of inpatient hospital services, AHCA would urge the Subcommittee to consider at this time a broader problem and its relationship to all providers of Medicaid services.

In placing AHCA's remarks in perspective, we would call your attention to the testimony of Mr. Stephen Kurzman, Assistant Secretary for Legislation, Department of Health, Education, and Welfare, before the Subcommittee on June 7, 1976. Mr. Kurzman testified that in the current fiscal year the federal government will provide Medicaid services to at least 23 million Americans at a cost of $15

billion. According to Mr. Kurzman, about 70 percent of these funds are spent for institutional care and are divided about evenly between inpatient hospital services and nursing home services.

Although the testimony before the Subcommittee has concerned the specific problem of hospital reimbursement in Illinois, AHCA believes that any consideration of an appeals system or forum whereby hospitals may contest their differences with states on reimbursement issues should also include Medicaid providers of skilled nursing and intermediate care services.

Section 1902(a)(13)(D) of Title XIX of the Social Security Act (42 U.S.C. § 1396a(a)(13)(D)) requires that providers of inpatient hospital services be reimbursed by states under Medicaid on the basis of reasonable cost as determined under the principles of reimbursement employed by the Title XVIII Medicaid program. Effective July 1, 1976, a state plan for medical assistance must also provide for payment for skilled nursing and intermediate care services on a reasonable cost-related basis. Section 1902(a)(13)(E) of the Social Security Act, 42 U.S.C. § 1396a(a)(13)(E). Therefore, reimbursement disputes between skilled nursing and intermediate care providers and states are every bit as likely as controversies between Medicaid providers of inpatient hospital services and states.

However, in contrast to Medicare,[1] the Medicaid laws do not specifically provide for any administrative and judicial review of Medicaid reimbursement disputes which may arise between the state and providers. Nor have states, in the absence of any federal requirement, established an appeals system for hearing Medicaid reimbursement disputes. Consequently, most states do not have a due process vehicle to resolve such disputes.

Under Secretary of Health, Education and Welfare, Majorie Lynch should be complimented for her candor before the House Committee on Interstate and Foreign Commerce. In responding to the Committee's request for reports on H.R. 12915 and H.R. 12961, she stated: "[T]here appear to be almost no States that have established administrative procedures in which providers may contest State reimbursement policy."[2]

This total absence of state provisions whereby Medicaid providers of skilled nursing and intermediate care services may obtain administrative and judicial consideration of a state's reimbursement rate, audit determination, or other reimbursement disputes has the effect of denying such providers constitutionally guaranteed due process rights. A recent New York State Supreme Court decision services to illustrate our point.[3]

A sole proprietor of a nursing home providing care to medically indigent patients in the City of Buffalo was audited in 1973 for the fiscal years ended September 30, 1970 and 1971. At the conclusion of the audit, the auditors met with the owner and his administrative assistant for the purpose of explaining the audit adjustments. An audit report was subsequently issued in which the provider had 30 days to file a written protest before the adjustments became final. Such a protest was filed.

Because of a *retroactive* decrease in the provider's reimbursement rate following the audit, the provider was allegedly overpaid for services during the period under audit in the sum of approximately $121,000. Payment in that amount was demanded from the provider.

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[1] *See* 20 C.F.R. §§ 405.1801–405.1889..

Under these regulations, fiscal intermediaries are required to establish and maintain procedures for resolving issues which arise between the fiscal intermediary and the providers of services as to amounts of program reimbursement due providers. The fiscal intermediary is to establish a hearing with hearing procedures, and to furnish written notice of the availability of such procedures to providers of services. A provider of services is given a right to a hearing if he is dissatisfied with the fiscal intermediary's determination and if the amount of reimbursement at issue is $1,000 or more.

In 1972 and 1974, Congress enacted provisions greatly expanding statutory review of Medicare provider reimbursement determinations. An amendment of 1972 established a Provider Reimbursement Review Board with jurisdiction to review reimbursement disputes where the amount in controversy exceeds $10,000. Social Security Amendments of 1972, Public Law 92–603, § 243(a), 42 U.S.C. § 139500. In 1974 Congress enlarged the review provision of 139500 to grant providers the rights to obtain judicial review, in a district court, of any decision of the statutory Board and of any reversal, affirmance, or modification of the Board's decision by the Secretary. Social Security Amendments of 1974, Public Law 93–484, § 3(a), 42 U.S.C. § 139500(f)(1). These provisions apply only to cost reporting periods ending on or after June 30, 1973. Social Security Amendments of 1972. Public Law 92–603, § 243(c).

[2] H. Rep. 94–1122 at 7, May 11, 1976.

[3] In the Matter of the Application of Bernard Birnbaum, doing business as *Abbott Manor Nursing Home* v. *Robert P. Whalen* as Commissioner of the Department of Health of the State of New York and Peter C. Goldmark, Jr., as Director of Budget of the State of New York, State of New York, Supreme Court, County of Monroe, Feb. 13, 1976.

Throughout the summer of 1975, the provider made several requests for a hearing at which it might present evidence in support of its reasonable cost contentions and at which it might cross-examine the auditors to ascertain or impeach the basis for their conclusions. It also urged that the hearing be before an impartial person who would make findings of fact on the basis of the evidence taken at such a hearing. Finally, the provider contended that the denial of this hearing request, as well as the lack of any opportunity to have such a hearing within the administrative procedures of the State Department of Health, constituted a deprivation of property without due process of law.

The Department of Health denied the provider's request on the basis that New York State's Medical Assistance Plan and the applicable rules and regulations did not provide for any type of administrative hearing either before or after an audit determination. The Department argued further that the exit conference after the audit, coupled with the review of the audit report by the State Health Commissioner, was sufficient to satisfy any due process requirements. The Court did not agree and held that the type of hearing sought by the provider was constitutionally required.

Many state and federal courts have reached a similar result. There does not appear to be any debate about the need for states to establish an appeals system for hearing reimbursement disputes which may arise between the state and a Medicaid provided. The present Medicaid statute provides that every Title XIX medical assistance plan must provide for an administrative due process hearing in any case of intended action (or failure to act) by the state agency responsible for administration of the Medicaid program which denies, terminates, suspends or reduces medical assistance benefits to an applicant or recipient.[4]

AHCA supports the recommendation of Robert List, Attorney General of the State of Nevada, and Chairman of the National Association of Attorneys General, Standing Committee on Health, Education and Welfare, that Congress should require a state to demonstrate the availability of administrative and judicial review to providers of Medicaid services desiring hearings of reimbursement disputes.

AHCA does not perceive any difficulty in determining the adequacy of these procedures. Recent decisions of the Supreme Court make clear the fundamental requirements of procedural due process.[5]

The form of any administrative hearing should be left to the discretion of the administrative authority with the caveat that the following minimal due process requirements must be met. There must be timely and adequate written notice detailing the reasons for the state's action. There must be a hearing (at which the provider may be represented by counsel) with an opportunity to present evidence and to confront and cross-examine adverse witnesses, and examine the documentary evidence of the adverse party. Additionally, the hearing body should consist of impartial and detached examiners, who should after the hearing issue a written statement as to the evidence relied upon and the reasons for the determination made. From this independent administrative review, the provider should have the right to judicial review in a state court of competent jurisdiction to resolve the dispute.

In line with these considerations, AHCA would suggest that Section 1902 of the Social Security Act, 42 U.S.C. § 1396a, be amended by adding at the end thereof the following new subsection:

"( ) Notwithstanding any other provision of this title, each State plan for medical assistance approved under this subchapter must provide procedures for an administrative due process hearing and judicial review in a court of competent jurisdiction of any claim, involving the construction, application, or legality of any method or standard developed by the State under Subsection (a)(13) of this Section, brought against the State or a State officer by or on

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[4] Section 1902(a)(3)—"provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). This statutory section has been implemented by federal regulations. 45 C.F.R. § 205.10.

[5] See, e.g., *Goldberg* v. *Kelly*, 397 U.S. 254 (1970). Although AHCA has pointed to the Medicare program as providing for administrative and judicial review of reimbursement disputes, there exists serious doubt whether the intermediary hearing procedures comport with minimum due process requirements. One District Court has concluded that without the intermediary or the Secretary as parties to the proceeding, the proceeding does not comport with minimum standards of due process or with the hearing guidelines that were suggested by the District Court in *Coral Gables Convalescent Home* v. *Richardson*, 340 F. Supp. 646 (S.D. Fla. 1972). *St. Jude Manor Nursing Home, Inc.* v. *Richardson*, No. 72-681-Civ.-J.-S. (M.D. Fla., Oct. 3, 1972).

behalf of any provider of services (as defined in section 1861(u)) with respect to reimbursement for services furnished under such plan."

This amendment would assure all Medicaid providers the opportunity to contest State reimbursement policies or decisions.

The language of the amendment is designed to provide for administrative and judicial review of all reimbursement claims regardless of whether they concern disputes involving the construction, application, or legality of State methods or standards of reimbursement. The administrative hearing would be required to comport with the due process requisites which AHCA has previously noted. Judicial review of the legality of such methods or standards would also be made available in courts of competent jurisdiction. This is significant because of the implied dilemma noted in Under Secretary Lynch's response to the House Committee on Interstate and Foreign Commerce:

". . . State court relief is unavailable to a provider in those States whose courts deem the Federal Government (which is not amenable to suit in State court) to be a necessary party to any action. Relief to the provider in Federal Court is also unavailable because of the Eleventh Amendment." [6]

The amendment as prepared by AHCA would obviate this problem by assuring state judicial review of *state* reimbursement methods or standards challenged on state grounds. In such instances, although review by federal courts would be precluded by the Eleventh Amendment if monetary reimbursement claims are involved and the state has not consented to suit in federal court, monetary and other relief would be available in state courts. The federal government would not be a necessary party in these cases because no federal questions would be raised, and no impact on federal law would be discernible.

In instances where the Medicaid claim involved the legality under federal law of federal reimbursement principles imposed upon the states, the federal government would be a necessary party. However, in those cases, as in cases challenging state reimbursement principles on federal grounds, providers could seek *prospective* injunctive or declaratory relief in federal courts. *Edelman* v. *Jordan*, 415 U.S. 651, 664–68 (1974); *Ex Parte Young*, 209 U.S. 123 (1908).

Though AHCA believes the amendment it offers would remove roadblocks to judicial review of Medicaid reimbursement disputes, the Committee may find other avenues of approach equally desirable. In his testimony before the Subcommittee, Assistant Secretary Kurzman explained that:

"HEW is not, however, opposed to legislation which would subject the states to the jurisdiction of the federal courts. For example, we would not object to a statute that deems continued state participation in the Medicaid program to be a waiver of its immunity to suits by providers in federal court. Such legislation would not place states in jeopardy of losing any Medicaid funds because of state incapacity to act within a given period."

Under this approach, no affirmative action by the state would be required to ensure judicial review. Accordingly, the need for sanctions would be non-existent. Instead, the Congress would simply enact a provision—in addition to that involving administrative remedies—evidencing its express intention that continued participation by the states in the Medicaid program is to be deemed a waiver of the states' Eleventh Amendment immunity. The state by its continued participation would grant such consent. *Edelman* v. *Jordan*, *supra*, 415 U.S. at 672; *Parden* v. *Terminal R. Co.*, 377 U.S. 184, 192 (1964).

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[6] H. Rep. 94–1122 at 7, May 11, 1976.

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